Department of Health

For the Year Ended
June 30, 1999

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John G. Morgan
Comptroller

April 13, 2000

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable Fredia S. Wadley, M.D., Commissioner
Department of Health
Cordell Hull Building, 426 Fifth Avenue North
Nashville, Tennessee 37247

Ladies and Gentlemen:

We have conducted a financial and compliance audit of selected programs and activities of the Department of Health for the year ended June 30, 1999.

We conducted our audit in accordance with generally accepted government auditing standards. These standards require that we obtain an understanding of management controls relevant to the audit and that we design the audit to provide reasonable assurance of the Department of Health's compliance with the provisions of laws, regulations, contracts, and grants significant to the audit. Management of the Department of Health is responsible for establishing and maintaining internal control and for complying with applicable laws and regulations.

Our audit disclosed certain findings which are detailed in the Objectives, Methodologies, and Conclusions section of this report. The department's administration has responded to the audit findings; we have included the responses following each finding. We will follow up the audit to examine the application of the procedures instituted because of the audit findings.

We have reported other less significant matters involving the department's internal control and/or instances of noncompliance to the Department of Health's management in a separate letter.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/ms
99/076

State of Tennessee

Audit Highlights

Comptroller of the Treasury — Division of State Audit

Financial and Compliance Audit
Department of Health
For the Year Ended June 30, 1999

AUDIT SCOPE

We have audited the Department of Health for the period July 1, 1998, through June 30, 1999. Our audit scope included those areas material to the Tennessee Comprehensive Annual Financial Report for the year ended June 30, 1999, and the Tennessee Single Audit Report for the same period. These areas include the Medical Assistance Program (Medicaid/TennCare); the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); the Block Grant for Prevention and Treatment of Substance Abuse (SAPT); and Federal Programs—Nonspecific. In addition to those areas, our primary focus was on management's controls and compliance with policies, procedures, laws, and regulations in the areas of contracts, revenue, contingent and deferred revenue, expenditures, Patient Tracking and Billing Management Information System, and utilization of the Department of Finance and Administration's STARS grant module to record the receipt and expenditure of federal funds. The audit was conducted in accordance with generally accepted government auditing standards.

AUDIT FINDINGS

Top Management Must Address TennCare's Administrative and Programmatic Deficiencies

The audit revealed many serious internal control deficiencies that have caused or exacerbated many of the TennCare program's problems (page 19).

TennCare Eligibility Verification Procedures Not Adequate**

For the past five years, TennCare has failed to implement effective eligibility procedures for uninsured and uninsurable enrollees. Eligibility determinations were not performed adequately, consistently, or timely; TennCare had no eligibility policies and procedures manual; and coordination and monitoring of the eligibility process was not adequate (page 24).

TennCare Management Information System Lacks the Necessary Flexibility and Internal Control*

Management of the Bureau of TennCare has not adequately addressed critical information system internal control issues. This has contributed to a number of other findings in this report (page 22).

TennCare Has Not Ensured the Department of Children's Services Payment Rates Are Reasonable and Approved by the Health Care Financing Administration**

TennCare has not ensured the Department of Children's Services has established federally approved Medicaid treatment rates for services provided for children in state custody (page 33).

TennCare-Related Activities at the Department of Children's Services Not Adequately Monitored**

TennCare has not adequately monitored the Department of Children's Services. Although TennCare recognized the need for a strong monitoring effort and has contracted with the Department of Finance and Administration to provide this service, the monitoring effort still needs improvement (page 35).

Authority Delegated to the Division of Mental Retardation Services in the Department of Finance and Administration

TennCare has delegated authority for eligibility determinations and authority to exercise administrative discretion for the Medicaid Home and Community Based Services Waiver to the Division of Mental Retardation Services in the Department of Finance and Administration in violation of the *Code of Federal Regulations*, Title 42, Part 431, Section 10 (page 37).

Communication Between the Department of Children's Services and TennCare Has Been Inadequate, Resulting in Questioned Costs of Over $9 Million

TennCare has paid the Department of Children's Services for services that were outside the scope of its agreement with the Bureau of TennCare during the year ended June 30, 1999 (page 28).

Allowable Rates for TennCare Mental Health Services Improperly Raised**

As a condition of the TennCare waiver, the state was allowed to continue paying for children's mental health services on a fee-for-service basis at the rates in existence prior to TennCare. During fiscal year 1995, however, the allowable amount for children's mental health services was raised for inflation. TennCare has not provided written approval from the Health Care Financing Administration for this action (page 34).

TennCare Did Not Ensure Adequate Monitoring of the Medicaid Home and Community Based Services

The TennCare Bureau did not ensure that the Division of Mental Retardation Services complied with its contract monitoring requirements (page 43).

Monitoring of the Medicaid Waiver for the Home and Community Based Services for the Mentally Retarded Was Not Adequate

The TennCare Bureau's monitoring of the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled under Section 1915(c) of the Social Security Act (HCBS waiver) is inadequate to provide the federally required assurances of health and welfare and of financial accountability (page 40).

Claims for Services Provided to the Mentally Retarded and Developmentally Disabled Were Not Properly Paid

TennCare has allowed other state departments to contract with and to pay Medicaid providers in violation of the terms of the Medicaid Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Waiver (page 44).

The TennCare Bureau Did Not Amend Its Cost Allocation Plan

The Medicaid cost allocation plan has not been amended to cover the administrative costs associated with the Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Waiver program (page 47).

TennCare Has Not Ensured an Adequate Process Is in Place for Approval and Review of Services for the Medicaid Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Waiver

TennCare has not ensured the Division of Mental Retardation Services (DMR) appropriately reviews and authorizes allowable services for recipients of the Medicaid Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Waiver. In addition, DMR does not adequately document the review and approval of services on the Individual Service Plan (page 48).

TennCare Should Develop Adequate Controls to Prevent Capitation Payments on Behalf of Enrollees Who Become Incarcerated, and Amend Its Policies to Permit Full Recovery of Related Overpayments

TennCare does not have adequate controls in place to prevent capitation payments to managed care organizations and behavioral health organizations when enrollees become incarcerated. In addition, TennCare does not have a process to retroactively recover all capitation payments from the MCOs when enrollees are incarcerated (page 49).

Deceased Enrollee Payment Recovery Procedures Need Improvement*

Procedures for deceased enrollee payment recovery need improvement. Although improvements have been made, testwork revealed several weaknesses (page 51).

Providers Not Paid in Accordance With Departmental Rules, and Processing of Medicare Cross-Over Claims Needs Improvement**

TennCare has not complied with departmental rules, resulting in overpayments to providers caring for enrollees who are both TennCare and Medicare recipients. TennCare has not improved controls in processing the Medicare cross-over claims (page 52).

Controls Over Access to the TennCare Management Information System Need Improvement*

The Director of TennCare is responsible for, but did not ensure that, adequate TennCare Management Information System (TCMIS) access controls were in place throughout the audit period. As a result, deficiencies in controls were noted during system security testwork (page 54).

Administration and Monitoring of TennCare Contracts Need Improvement

Services were performed and paid for without a contract, and one contract was outdated and inadequate. TennCare had no written contract monitoring policies and procedures to ensure compliance with contract provisions (page 56).

TennCare Committed Funds Without Approval

Since July 1, 1999, the Department of Health, Bureau of TennCare, committed state and federal TennCare funds before it had a contract with the Department of Children's Services to provide services. As of December 10, 1999, an interdepartmental grant agreement had not been executed for the period July 1, 1999, through June 30, 2000 (page 58).

Subrecipients Not Monitored by TennCare*

TennCare did not monitor the state's medical schools to ensure that requirements related to graduate medical education payments (approximately $48 million in fiscal year 1999) were met, nor did TennCare advise the medical schools of the audit requirements of subrecipients (page 59).

Millions in State Funds Remitted to Federal Government Because of Uncollected Provider Cost Settlements**

Because TennCare still failed to collect Medicaid cost settlements from providers, state funds ($10.2 million as of June 30, 1999) were used to pay the federal portion of the cost settlements. The federal grantor requires states to remit the federal share (approximately two-thirds) within 60 days of settlement, whether or not the state has collected the amounts due from the providers (page 60).

TennCare's Accounts Receivable Policies and Procedures Not Adequate*

As noted in the prior audit, TennCare has not established adequate overall policies and procedures for accounts receivable. Testwork also revealed discrepancies in the controls over enrollee premiums receivable (page 63).

Policies and Procedures for TennCare's Accrued Liabilities Need Improvement*

TennCare's inadequate policies and procedures for accrued liabilities resulted in an $80 million financial adjustment to the state's general fund (page 65).

Controls Over Checks Should Be Strengthened

Weaknesses in check procedures pertaining to poor segregation of duties, physical security, and the reconciliation of issued checks and paid checks were noted. For the year ended June 30, 1999, these checks totaled over $3.6 billion (page 66).

Noncompliance With the Special Terms and Conditions of the TennCare Waiver

Management did not comply with nine of 24 applicable special terms and conditions (STCs) of the TennCare Waiver, and controls over compliance with the STCs need improvement. Federal financial participation in the program is contingent upon compliance with the STCs (page 68).

Internal Control Over Provider Eligibility and Enrollment Not Adequate to Ensure Compliance**

TennCare's internal controls for provider eligibility and enrollment were not adequate to ensure compliance with Medicaid provider regulations (page 70).

TennCare Did Not Comply With Federal Regulations and State Plan Provisions Concerning Unnecessary Utilization of Services and Suspected Fraud

TennCare did not comply with federal regulations and provisions of the state plan concerning unnecessary utilization of services and suspected fraud for Medicaid claims still paid under the fee-for-service arrangement (page 76).

Audit Requirements for Long-Term Care Facilities Not Followed

The Bureau of TennCare did not ensure that audits of long-term care facilities were performed in accordance with the state plan and the departmental rules for Medicaid (page 79).

ADP Risk Analysis and System Security Review Program Not Established**

TennCare still does not have a coordinated program for automated data processing (ADP) risk analysis and system security review of the TennCare Management Information System, as required by the federal grantor (page 81).

TennCare Incorrectly Approved a Pre-Admission Evaluation

TennCare inappropriately approved a pre-admission evaluation (PAE) and allowed an individual to receive services without a physician's order (page 83).

Revision of TennCare's Rules Needed**

Several departmental rules governing TennCare were inconsistent with TennCare's practices (page 84).

No Procedures to Detect Dual Participation in the WIC and CSFP Programs

The department has no procedures to ensure that dual participation between the Special Supplemental Food Program for Women, Infants, and Children (WIC) and the Commodity Supplemental Food Program (CSFP) will be detected (page 93).

Accounting for SAPT Grant Expenditures Is Not Adequate

The department has not established specific cost centers in the State of Tennessee Accounting and Reporting System (STARS) for classification of expenditures for HIV services and treatment services for pregnant women and women with dependent children; therefore, the required expenditure levels cannot be traced to STARS (page 94).

Subrecipients' Audit Reports Are Not Adequately Monitored**

As noted in the seven prior audits, the subrecipients' audit reports were not received timely; did not contain the required schedules; and audit exceptions, including questioned costs, noted in the reports were not followed up or resolved timely (page 95).

Incorrect Grant-Funding Information in the State's Property Records
The department did not record correct grant information for equipment items that were federally funded (page 98).

Inadequate Contract Controls*
The department failed to approve contracts before the beginning of the contract period (page 100).

PAST FINDINGS NOT ACTED UPON BY MANAGEMENT

Prior audits of the Department of Health have contained findings concerning the drawdown and use of indirect cost funds, implementation of effective controls in the Nursing Home Resident's Grant Assistance Program, and supplemental pay. Although these findings have been reported for many years, management has not taken action, and has no plans to take action, to fully resolve the matters discussed in the findings. These findings will not be repeated in subsequent audit reports.

Drawdown and Use of Indirect Cost Funds
The Department of Health has not fully used the departmental indirect cost allocation plan for the recovery of indirect costs from block grants. Management uses eligible indirect costs for program expenditures and spends a large portion of previously recovered indirect costs for program services (page 4).

Administrative Controls for the Nursing Home Resident's Grant Assistance Program
The Department of Health has not established adequate administrative controls over the Nursing Home Resident's Grant Assistance Program to ensure participant eligibility and contractor performance, nor has the department set per diem limits (page 5).

Supplemental Pay
The Department of Health, without authorization, has allowed certain employees to receive supplemental pay from the counties employing them. Section 68-2-603, Tennessee Code Annotated, states that county health directors and county health officers "shall have compensation paid, all or in part, by the department of health." However, there is no provision in the law granting authority for supplemental pay to employees other than county health directors and county health officers (page 6).

* This finding is repeated from the prior audit.
** This finding is repeated from prior audits.

"Audit Highlights" is a summary of the audit report. To obtain the complete audit report which contains all findings, recommendations, and management comments, please contact

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Audit Report
Department of Health
For the Year Ended June 30, 1999

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Department of Health
For the Year Ended June 30, 1999

INTRODUCTION

POST-AUDIT AUTHORITY

This is the report on the financial and compliance audit of the Department of Health. The audit was conducted pursuant to Section 4-3-304, *Tennessee Code Annotated*, which authorizes the Department of Audit to "perform currently a post-audit of all accounts and other financial records of the state government, and of any department, institution, office, or agency thereof in accordance with generally accepted auditing standards and in accordance with such procedures as may be established by the comptroller."

Section 8-4-109, *Tennessee Code Annotated*, authorizes the Comptroller of the Treasury to audit any books and records of any governmental entity that handles public funds when the Comptroller considers an audit to be necessary or appropriate.

BACKGROUND

The mission of the Department of Health is to promote, protect, and restore the health of Tennesseans by facilitating access to high-quality preventive and primary care services. To fulfill this mission, the department comprises eight functional sections: Executive Administration; Office of Budget and Finance; Bureau of Information Systems; Office of Health Licensure and Regulations; Bureau of Alcohol and Drug Abuse Services; Bureau of Health Services; Policy Planning and Assurance; and Bureau of TennCare.

One of the department's many responsibilities is to provide overall direction to, coordination of, and supervision for the state and local health departments to enable them to meet the health needs of the state's citizens. The department ensures the quality of medical resources available in the state through the regulation, certification, and licensure of health professionals and health care facilities. The central office works in coordination with four rural and six metropolitan regional offices and 95 county health departments to provide services, which protect and promote health and prevent disease and injury. The department also works to improve access to quality health care services in underserved areas of the state and to underserved populations. To decrease the incidence and prevalence of alcohol and other drug abuse and dependence, the department coordinates prevention, treatment, and rehabilitation services. The department is also responsible for preserving and issuing copies of all vital records.

The Bureau of TennCare administers the TennCare program, the state's managed health care program for eligible low-income, disabled, uninsurable, and uninsured individuals.

TennCare was implemented in January 1994 after the state obtained a waiver from the federal Health Care Financing Administration, which allowed the state to replace its basic Medicaid program (Medical Assistance Program) with a managed care system. The TennCare Partners managed care program, implemented in July 1996, provides mental health and substance abuse treatment services to TennCare recipients. The department contracts with managed care organizations (MCOs) and behavioral health organizations (BHOs) to pay providers for the delivery of health care services.

The Bureau of TennCare also is responsible for administration of the state's Medicaid programs for long-term care and home- and community-based services, as well as the department's contract with the Department of Children's Services for case management and children's therapeutic intervention services. In addition, TennCare pays "Medicare cross-over" medical claims on behalf of recipients who are eligible for both Medicare and Medicaid.

Executive Order 24 was issued on October 19, 1999, to transfer the TennCare program and its related functions and administrative support from the Department of Health to the Department of Finance and Administration.

AUDIT SCOPE

We have audited the Department of Health for the period July 1, 1998, through June 30, 1999. Our audit scope included those areas material to the Tennessee Comprehensive Annual Financial Report for the year ended June 30, 1999, and to the Tennessee Single Audit Report for the same period: the Medical Assistance Program (Medicaid/TennCare); the Special Supplemental Nutrition Program for Women, Infants, and Children; the Block Grant for Prevention and Treatment of Substance Abuse; and Federal Programs—Nonspecific. In addition to those areas, our primary focus was on management's controls and compliance with policies, procedures, laws, and regulations in the areas of contracts, revenue, contingent and deferred revenue, expenditures, Patient Tracking and Billing Management Information System, and utilization of the Department of Finance and Administration's STARS grant module to record the receipt and expenditure of federal funds. The audit was conducted in accordance with generally accepted government auditing standards.

PRIOR AUDIT FINDINGS

Section 8-4-109, *Tennessee Code Annotated*, requires that each state department, agency, or institution report to the Comptroller of the Treasury the action taken to implement the recommendations in the prior audit report. The Department of Health filed its report with the Department of Audit on December 17, 1999. A follow-up of all prior audit findings was conducted as part of the current audit.

RESOLVED AUDIT FINDINGS

The current audit disclosed that the Department of Health has corrected the following previous audit findings concerning

- the effective merger of the Department of Health and the Department of Mental Health and Mental Retardation;
- the Medicaid Accounts Receivable Recoupment System;
- the TennCare Management Information System updates to timely process Mental Health and Mental Retardation Claims;
- obtaining information for the TennCare audit;
- the loss of $55,000 in federal matching funds;
- monitoring the TennCare eligibility of Supplemental Security Income recipients;
- the use of memorandum of understanding agreements;
- incorrect reimbursement to the Department of Children's Services for administrative leave with pay;
- Medicaid grant refunds;
- inadequate revenue controls at various locations; and
- employer-employee relations.

REPEATED AUDIT FINDINGS

The prior audit report also contained findings concerning

- the TennCare management information system's lack of flexibility and internal controls;
- internal controls over TennCare eligibility;
- payments for ineligible incarcerated youth;
- the intent of grant requirements;
- monitoring of TennCare-related activities at the Department of Children's Services;

- recovery procedures for payments on behalf of deceased enrollees;
- providers not paid in accordance with departmental rules;
- Medicare "professional cross-over" claims processing;
- controls over access to the TennCare Management Information System;
- monitoring the graduate medical schools;
- uncollected cost settlements;
- policies and procedures for accounts receivable;
- policies and procedures for accrued liabilities;
- internal controls over provider eligibility and enrollment;
- ADP risk analysis and system security review;
- revision of departmental rules;
- monitoring of subrecipients' audit reports; and
- untimely approval of contracts.

These findings have not been resolved and are repeated in the applicable sections of this report.

PAST FINDINGS NOT ACTED UPON BY MANAGEMENT

Prior audits of the Department of Health have contained findings concerning the drawdown and use of indirect cost funds, implementation of effective controls in the Nursing Home Resident's Grant Assistance Program, and supplemental pay. Although these findings have been reported for many years, management has not taken action, and has no plans to take action, to fully resolve the matters discussed in the findings. These findings will not be repeated in subsequent audit reports.

Drawdown and Use of Indirect Cost Funds

The Department of Health has not fully used the departmental indirect cost allocation plan for the recovery of indirect costs from block grants. Management uses eligible indirect costs for program expenditures and spends a large portion of previously recovered indirect costs for program services.

The department enters into an annual agreement with the Division of Cost Allocation in the U.S. Department of Health and Human Services specifying the terms of the indirect cost allocation plan. The plan identifies departmental, bureau, divisional, and statewide indirect

costs. The departmental, bureau, and divisional indirect costs are those incurred at a particular level for a common purpose, which benefit more than one program, function, or activity, and therefore are not directly assignable to a single program, function, or activity. Statewide indirect costs are the costs of central governmental services distributed through the statewide cost plan that are not otherwise treated as direct costs. Using the indirect cost allocation plan, the department can allocate total indirect costs by bureau or by division.

When indirect costs are not systematically drawn as a part of the program's operating costs, they are, in effect, hidden and must be paid from other sources. Although the allocation of indirect costs may actually shift the use of available federal funds from program operations to administrative overhead, the allocation is essential to present fairly the costs of administering the programs. Likewise, when earned indirect costs are used to fund program services, the true level of state expenditures incurred to fund the program is hidden, and state funds are used to fund activities at the departmental level. The decision whether additional state funds should be used for federal programs is more appropriately addressed through the legislative budget process than by each department.

Management has concurred with the finding, stating that the department's policy is to maximize the utilization of all available federal grant dollars and that the budget is predicated and reflective of these efforts. Furthermore, management has stated that any policy or procedural change requiring indirect cost funds to be used solely for administrative expenditures would necessitate a budget reorganization within the department that would have to be approved by the Commissioner of Finance and Administration and the legislature through the Appropriation Request process. However, the Department of Health has not revised its budget to address this issue, pending an official F&A policy or directive to do so. Procedures have been implemented that will ensure recognition of the true level of state expenditures incurred to fund a program with federal funding. For any grant with an ending date subsequent to July 1, 1998, indirect cost earned will be recognized in the state's accounting system (STARS) and identified as "state" funded if federal funds are not drawn.

Administrative Controls for the Nursing Home Resident's Grant Assistance Program

The Department of Health has not established adequate administrative controls over the Nursing Home Resident's Grant Assistance Program to ensure participant eligibility and contractor performance, nor has the department set per diem limits.

The program's intent is to provide a small amount of assistance to nursing home residents whose care is not paid by a state or federal program and who are income-eligible.

A private contractor is responsible for maintaining a systematic process to provide financial support for eligible individuals. However, neither the department nor the contractor verifies the accuracy of information on the applications or on the documents each nursing home completes to certify the number of days residents did not receive other assistance and to report the average per diem expense. In addition, the department does not monitor the program contractor.

If patient eligibility and contractor performance are not monitored, funds could be disbursed to ineligible participants.

Management concurred in part with the finding, stating that as the program was planned and designed, the department believed certain controls would not be cost-effective or reasonable. Management also stated that although there are some very broad eligibility requirements in the law establishing this program, certain other financial eligibility information verification is left to the discretion of the department. When designing the program, the department chose not to further verify participant eligibility or the accuracy of information reported by nursing homes. Management agreed that the department could develop and implement procedures to more accurately verify participant eligibility and the accuracy of information reported by nursing homes, but stated that it was not appropriate to do so, particularly in the early stages of developing the program, given the population involved, the intent of the program, and the relatively small grant amounts available. Management said the department would look at this situation further to determine if additional, more formal procedures were needed to adequately monitor the program contractor. The department is working with the program contractor to determine if procedures can be implemented to monitor grant payments for eligibility.

Supplemental Pay

The Department of Health, without authorization, has allowed certain employees to receive supplemental pay from the counties employing them. Section 68-2-603, *Tennessee Code Annotated*, states that county health directors and county health officers "shall have compensation paid, all or in part, by the department of health." However, there is no provision in the law granting authority for supplemental pay to employees other than county health directors and county health officers.

Although the Department of Health has concurred with this repeat finding, its position until 1996 was to allow no new unauthorized employees to receive supplemental pay, claiming that attrition would correct the situation. In 1996, however, the department increased the positions. Of the positions added in 1996, only two were unauthorized. These two positions were removed in 1996 and new procedures were implemented to prevent the addition of unauthorized employees to the supplemental pay listing. No new positions have been added since 1996.

OBJECTIVES, METHODOLOGIES, AND CONCLUSIONS

AREAS RELATED TO TENNESSEE'S COMPREHENSIVE ANNUAL FINANCIAL REPORT AND SINGLE AUDIT REPORT

Our audit of the Department of Health is an integral part of our annual audit of the Comprehensive Annual Financial Report (CAFR). The objective of the audit of the CAFR is to render an opinion on the State of Tennessee's general-purpose financial statements. As part of

our audit of the CAFR, we are required to gain an understanding of the state's internal controls and determine whether the state complied with laws and regulations that have a material effect on the state's general-purpose financial statements.

Our audit of the Department of Health is also an integral part of the Tennessee Single Audit which is conducted in accordance with the Single Audit Act, as amended by the Single Audit Act Amendments of 1996. The Single Audit Act, as amended, requires us to determine whether

- the state complied with rules and regulations that may have a material effect on each major federal financial assistance program, and

- the state has internal control to provide reasonable assurance that it is managing its major federal award programs in compliance with applicable laws and regulations.

We determined the following areas within the Department of Health were material to the CAFR and to the Single Audit Report: the Medical Assistance Program (Medicaid/TennCare); the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); and the Block Grant for Prevention and Treatment of Substance Abuse (SAPT).

To address the objectives of the audit of the CAFR and the Single Audit Report, as they pertain to these three major federal award programs, we interviewed key department employees, reviewed applicable policies and procedures, and tested representative samples of transactions. For further discussion, see the applicable section (Medicaid/TennCare, WIC, and SAPT).

We have audited the general-purpose financial statements of the State of Tennessee for the year ended June 30, 1999, and have issued our report thereon dated December 10, 1999. The opinion on the financial statements is unqualified. The Tennessee Single Audit Report for the year ended June 30, 1999, includes our reports on the schedule of expenditures of federal awards and on internal control and compliance with laws and regulations. These reports include reportable conditions and material weaknesses resulting from this audit. These reports also include instances of noncompliance, some of which resulted in a qualified opinion on compliance requirements of the federal Medicaid/TennCare program.

The audit of the department revealed the following findings in areas related to the CAFR and the Single Audit Report:

- The TennCare program had significant weaknesses and needs improvement as discussed in findings 1 through 31.

- The department had no procedures to detect dual participation in the WIC and Commodity Supplemental Food Program. See finding 32.

- The department did not appropriately account for the Block Grant for Prevention and Treatment of Substance Abuse expenditures. See finding 33.

- We also noted departmental weaknesses in monitoring (as noted in finding 34) and in recording correct grant-funding information in the state's property records (as noted in finding 35) which affected the WIC and SAPT programs.

MEDICAL ASSISTANCE PROGRAM (MEDICAID/TENNCARE)

The Medical Assistance Program (Medicaid/TennCare) is the largest federal program in the "Medicaid cluster" of grant programs. The State Medicaid Fraud Control Units and the State Survey and Certification of Health Care Providers and Suppliers grant programs are also included in the Medicaid cluster. These two programs provide significant controls over the expenditures of Medicaid funds.

Our audit of the TennCare program focused primarily on the following areas:

- General Internal Control
- Activities Allowed or Unallowed and Allowable Costs / Cost Principles
- Cash Management
- Eligibility
- Matching, Level of Effort, Earmarking
- Period of Availability of Federal Funds
- Procurement and Suspension and Debarment
- Program Income
- Federal Reporting
- Subrecipient Monitoring
- Special Tests and Provisions
- Schedule of Expenditures of Federal Awards
- Financial (Accounts Receivable, Accrued Liabilities, Other Liabilities)
- TennCare Management Information System General Controls

The primary audit objectives, methodologies, and our conclusions for each area are stated below. For each area, auditors documented, tested, and assessed management's controls to ensure compliance with applicable laws, regulations, grants, contracts, and state accounting and reporting requirements. To determine the existence and effectiveness of management's controls,

auditors administered planning and internal control questionnaires; reviewed policies, procedures, and grant requirements; prepared internal control memos, performed walk-throughs, and performed tests of controls; and assessed risk.

General Internal Control

Our primary objectives for general controls were to obtain an understanding of, document, and assess management's general controls and to follow up on the prior audit finding concerning departmental rules. We interviewed key program employees; reviewed organization charts, descriptions of duties, and responsibilities for each division, and correspondence from the grantor; and considered the overall control environment of the TennCare program. We also reviewed the current departmental rules and interviewed key employees to determine the status of the discrepancies noted in the prior audit finding.

We noted several deficiencies in management's general controls over the TennCare program, as described in finding 1. We also determined that TennCare still had not adequately complied with or revised its rules, as discussed in finding 31.

Activities Allowed or Unallowed and Allowable Costs / Cost Principles

The primary objectives of this area were as follows:

- to determine if grant funds were expended only for allowable activities;
- to determine whether TennCare has procedures in place to provide reasonable assurance that HCBS (Home and Community Based Services) waiver funds were expended only for waiver allowable activities;
- to determine if recipients of HCBS waiver services were eligible for services under the appropriate waiver and if TennCare ensured that the administrative lead agency for the HCBS waiver followed TennCare guidelines for determining eligibility for HCBS waiver services;
- to determine if TennCare and the administrative lead agency had an effective formal monitoring process in place for the HCBS waiver program; and
- to determine if processes were in place to ensure HCBS waiver claims were submitted in time to obtain federal financial participation during the authorized period of availability.

To determine if grant funds were expended for allowable activities only, we performed computer-assisted audit techniques (CAATs) to test payments to the managed care organizations (MCOs) and behavioral health organizations (BHOs) to determine if the correct capitation amount had been paid. We tested nonstatistical samples of Medicaid claims (e.g., nursing home claims) to determine if the claims were paid correctly and if claims were pursuant to the order of

a physician. CAATs were used to search the payment data files for payments made on behalf of deceased enrollees and adult prisoners.

A nonstatistical sample of reimbursement claims paid to the Department of Children's Services (Children's Services) was tested. Supporting documentation for the claims was examined to determine if the charges were valid and allowable. The related case files at the community services agencies and the vendors were reviewed for evidence that the children in the sample had actually received the services for which TennCare had reimbursed Children's Services. CAATs were used to search payment data files that contained payments made by TennCare to Children's Services for payments made on behalf of incarcerated youth, individuals over 21, and services that should be covered by the BHOs. In addition, we used CAATs to identify payments made to Children's Services on behalf of children under three years of age receiving behavioral health services.

Supporting documentation for all significant expenditure items was obtained and examined. We performed reconciliations to determine if the amounts recorded in STARS agreed with the amount of checks issued and reported in federal reports. Significant supplemental funding pool payments were recalculated to test for compliance with the payment methodologies approved by the grantor.

To achieve the objectives related to the HCBS waiver, we reviewed the Home and Community Based Services for the Mentally Retarded and Developmentally Disabled waiver (HCBS waiver) and inquired about its operation. An assessment of internal controls involving eligibility of recipients and payment of claims was performed for the HCBS waiver. Key employees were interviewed at the Division of Mental Retardation Services (DMR) in the Department of Finance and Administration for information concerning the Division's responsibilities with the waiver. A nonstatistical sample of claims was selected to test recipient eligibility, expenditure allowability, and claims processing and recording.

The results of this area were as follows:

- TennCare has not complied in all material respects with federal allowable cost requirements. As noted in finding 4, TennCare paid Children's Services over $9 million in unallowable costs (i.e., payments for incarcerated youth, children under the age of three, individuals over 21 years old, cost of services covered by BHOs, and costs of services inadequately documented). As noted in finding 5, TennCare has not ensured that the Children's Services payment rates were reasonable. As noted in finding 6, TennCare has not obtained approval for increases in payment rates to Children's Services. As noted in finding 7, TennCare has not adequately monitored Children's Services to ensure the allowability of costs. As noted in finding 12, TennCare has not amended its cost allocation plan, which resulted in unallowable costs of over $6 million. As noted in finding 13, TennCare has not ensured DMR has an adequate process in place for approval and review of services, and as a result, TennCare paid for services that were not adequately approved. As noted in finding 14, TennCare incorrectly used federal funds to pay over $1 million in capitation payments to MCOs and BHOs for incarcerated adults. As noted in finding 15, TennCare does not retroactively recover all payments made on behalf of deceased

enrollees. As noted in finding 16, TennCare does not pay Medicare cross-over providers in accordance with its own rules. As noted in finding 30, TennCare inappropriately approved a pre-admission evaluation without a physician's order, which resulted in unallowable costs.

- TennCare's supporting documentation for significant expenditure items was reasonable.

- Testwork revealed that amounts recorded in STARS agreed with the amounts of checks issued and reported in federal reports.

- Significant supplemental funding pool payments were in compliance with the payment methodologies approved by the grantor.

- TennCare does not have adequate procedures in place to provide reasonable assurance that HCBS waiver funds were expended only for waiver allowable activities as noted in finding 11.

- Testwork revealed that recipients of HCBS waiver services were eligible. However, TennCare has not ensured that the administrative lead agency for the HCBS waiver followed TennCare guidelines for determining eligibility for HCBS waiver services as noted in finding 8.

- TennCare and the administrative lead agency did not have an effective formal monitoring process in place for the HCBS waiver program as noted in findings 9 and 10.

- Processes were in place to ensure HCBS waiver claims were submitted in time to obtain federal financial participation during the authorized period of availability.

- TennCare committed state and federal TennCare funds before it had a contract with the Department of Children's Services to provide services (see finding 19).

Cash Management

Our objectives for this area were to determine

- if management complied with the terms and conditions of the Cash Management Improvement Act Agreement between the state and the Secretary of the Treasury, United States Department of the Treasury (State-Treasury Agreement), and

- if the federal share of program refunds was remitted promptly to the grantor.

We tested nonstatistical samples of federal cash drawdown transactions for compliance with the State-Treasury cash management agreement. A nonstatistical sample of grant refunds

was tested to determine if the federal share of the refunds was properly and timely returned to the grantor.

Based on the testwork performed, we determined that management had complied, in all material respects, with the State-Treasury cash management agreement and that program refunds were remitted as required.

Eligibility

Our primary objectives were to determine whether controls over eligibility determinations and verifications / reverifications were adequate and if TennCare enrollees were eligible according to TennCare rules and regulations.

Using information in the Automated Client Certification Eligibility Network for Tennessee (ACCENT) system and the TennCare Management Information System (TCMIS), we tested a nonstatistical sample of payments made on behalf of Medicaid-eligible TennCare enrollees to determine if the individuals were eligible for TennCare on the dates of service for which the payment had been made. We also tested a nonstatistical sample of payments made on behalf of uninsured and uninsurable TennCare enrollees to determine if the individuals met the eligibility requirements and if TennCare had verified or reverified the enrollees' eligibility within a year of the dates of service for which the payment had been made.

We used CAATs to verify whether the only payments made on behalf of "state-only" TennCare enrollees were payments to the BHOs. (State-only enrollees are only eligible for mental health services and the cost of care is paid for with 100% state funds.) Also, a nonstatistical sample of state-only recipients enrolled during the year ended June 30, 1999, was tested to determine whether the correct eligibility classification code was used when the individual was entered into the TCMIS. In addition, CAATs were used to search TennCare's payment files for payments made for TennCare enrollees with invalid social security numbers.

Testwork revealed that controls over eligibility for the Medicaid eligible and state-only enrollees were adequate and that Medicaid eligible enrollees were eligible according to TennCare rules and regulations. However, we determined that internal control over eligibility for the uninsurable and uninsured population was not adequate and that TennCare had not complied, in all material respects, with federal eligibility grant requirements. Because so few enrollees in our uninsured and uninsurable samples had been verified or reverified timely, we could not determine if individuals were eligible as of the dates of service in our sample. As a result, the finding concerning TennCare eligibility from the prior audit has been repeated in this report and payments made on behalf of enrollees not properly determined eligible were noted as questioned costs. CAATs revealed that TennCare made payments for TennCare enrollees with invalid social security numbers. See finding 3 for more information.

Matching, Level of Effort, Earmarking
Period of Availability of Federal Funds

The primary objectives of this area were as follows:

- to provide reasonable assurance that matching requirements were met using only allowable funds or costs which were properly calculated and valued; and

- to provide reasonable assurance that federal funds were used only during the authorized period of availability.

To provide reasonable assurance that matching requirements were met using only allowable funds or costs which were properly calculated and valued, we interviewed the key personnel responsible for this function in the Division of Budget and Finance and examined selected reports. We obtained and reviewed documentation from the grantor concerning the approved period of availability of federal funds and compared it to total federal program expenditures.

Based upon the testwork performed, it appeared that TennCare was complying with matching requirements using only allowable funds or costs which were properly calculated and valued. In addition, federal funds were used only during the authorized period of availability.

Procurement and Suspension and Debarment

Our objectives were to provide reasonable assurance that procurement of goods and services was made in compliance with the provisions of applicable regulations and guidelines, and that no subaward, contract, or agreement for purchase of goods or services was made with any debarred or suspended party.

We reviewed the OMB Circular A-133 *Compliance Supplement* for internal control and compliance requirements for procurement and suspension and debarment and the agency program requirements under the Medicaid cluster. In addition, key employees were interviewed and walk-throughs were performed regarding TennCare's procurement of goods and services and compliance with federal requirements. We reviewed all nongovernmental contracts for $100,000 or more in effect during the year ended June 30, 1999, to determine if the contracts contained the required certifications concerning suspended or debarred parties and suspended or debarred principals. We performed testwork on TOPS (Tennessee on-line purchasing system) to determine if procurements of goods were made in compliance with the policies and procedures required by the State of Tennessee.

We detected control weaknesses in the administration and monitoring of contracts, as discussed in finding 18. Based on the testwork performed, however, it appeared that management had complied with procurement requirements, including requirements concerning debarred and suspended parties.

Program Income

Our objective was to provide reasonable assurance that program income was correctly earned, recorded, and used in accordance with the program requirements.

TennCare's program income consists of premiums paid by uninsured and uninsurable TennCare enrollees based on their income and family size. We used a nonstatistical sample of monthly capitation payments to determine if the premium amounts billed to the recipients for whom the payments were made were correct according to enrollee information in the TennCare Management Information System (TCMIS) and the premium calculation tables in the Rules for the Bureau of TennCare.

We also compared the total amount of premium revenue collected according to TCMIS reports and the amount recorded in the state's accounting records (STARS). In order to determine if the federal share of program income was used to reduce federal expenditures, as required, we recalculated the federal share for each quarter and reviewed the quarterly federal expenditure reports.

We determined that internal control over premiums was not adequate to provide reasonable assurance that program income was earned and recorded in accordance with program requirements, as discussed in finding 22. Based on the testwork performed, however, it appeared that premiums were used to reduce federal expenditures, as required.

Federal Reporting

Our objective was to ensure that reports of federal awards submitted to the federal awarding agency included all activity of the reporting period, were supported by underlying accounting or performance records, and were submitted in accordance with program requirements.

We inquired of management about the requirements and procedures for preparing, reviewing, and submitting program financial and progress reports. We selectively tested the mathematical accuracy of the reports, reviewed supporting documentation for the information presented, and determined if the reports were prepared in accordance with grant guidelines and requirements.

We noted that TennCare had not complied with federal requirements for preparing program progress reports, as discussed in finding 25. However, based on the testwork performed, it appeared that, in all material respects, reports of federal awards included all activity of the reporting period, were supported by underlying records, and were submitted in accordance with program requirements.

Subrecipient Monitoring

The primary objective of this area was to determine whether subrecipients (graduate medical schools) were properly monitored to ensure compliance with federal award requirements.

We inquired of management about procedures for monitoring subrecipients, reviewed the requirements for payments to the state's four medical schools for graduate medical education, and tested the payments to determine if the amounts paid were correct.

TennCare has not properly monitored the graduate medical schools to ensure compliance with federal award requirements as noted in finding 20.

Special Tests and Provisions

Special Tests and Provisions (ST&P) consists of the following: Utilization Control and Program Integrity, Long-Term Care Facility Audits, Provider Eligibility and Provider Health and Safety Standards, and Managed Care. Each ST&P is discussed separately below.

Utilization Control and Program Integrity

Our main objectives were to determine whether the state had established and implemented procedures to (1) safeguard against unnecessary utilization of care and services, including long-term care institutions; (2) identify suspected fraud cases; (3) investigate these cases; and (4) refer those cases with sufficient evidence of suspected fraud to law enforcement officials.

Key employees were interviewed about procedures related to utilization control and program integrity. We tested a nonstatistical sample of case files in the Program Integrity Unit to determine if the appropriate steps were taken to investigate suspected cases of fraud and, if appropriate, to refer them to law enforcement officials. We also interviewed the Special Agent In-Charge of the Medicaid Fraud Control Unit, which is part of the Tennessee Bureau of Investigation.

We noted that controls were not adequate to ensure compliance with federal requirements regarding unnecessary utilization of care and services and identification of suspected fraud. In addition to these control deficiencies, we determined that management had not complied with the *Code of Federal Regulations,* Title 42, parts 455, 456, and 1002, which requires the state to have procedures to safeguard against unnecessary utilization of care and services. See finding 27 for more information about these matters. Based on the testwork performed, however, it appeared that noted cases of suspected fraud were properly investigated by the Program Integrity Unit, and that procedures existed to refer those cases with sufficient evidence to law enforcement officials.

Long-Term Care Facility Audits

Our objective was to determine whether the state Medicaid agency performed long-term care facility audits as required.

Key personnel at the Bureau of TennCare and the Medicaid/TennCare section of the Comptroller's Office were interviewed about compliance with audit requirements, and related documents were reviewed. We reviewed a nonstatistical sample of long-term care facility cost reports to determine if the reports had been desk-reviewed in accordance with program requirements.

We determined that controls were not adequate to ensure compliance with federal and state requirements for long-term care facility audits, and that management had not complied with the audit requirements. See finding 28 for more information about these matters.

Provider Eligibility and Provider Health and Safety Standards

Our objectives were

- to determine whether providers of medical services were licensed to participate in the Medicaid program in accordance with federal, state, and local laws and regulations, and whether the providers had made the required disclosures to the state; and

- to determine whether the state ensured that nursing facilities and intermediate care facilities for the mentally retarded that serve Medicaid patients met the prescribed health and safety standards.

Nonstatistical samples of payments to providers were tested to determine if the providers met the appropriate professional standards (e.g., were licensed in accordance with applicable laws and regulations) on the dates of service for which the payments had been made. The types of providers tested were Medicare cross-over providers, Department of Children's Services' providers, and providers for the Home and Community Based Services Waiver for the Developmentally Disabled and the Mentally Retarded program. We also reviewed the provider agreements to determine if they complied with federal regulations, including the disclosure requirements.

In addition, we tested a nonstatistical sample of payments to long-term care providers to determine whether the providers met the prescribed health and safety standards, and if TennCare's agreements with the facilities were in compliance with applicable laws and regulations on the dates of service for which the payments had been made.

We noted that internal control over provider eligibility and enrollment was not adequate to ensure compliance with federal regulations. Also, management did not comply with all regulations for provider eligibility; noncompliance with licensure and provider agreement requirements resulted in federal questioned costs. These matters are discussed further in a repeated audit finding 26. Our testwork did determine that all of the long-term care providers tested met the prescribed health and safety standards.

Managed Care

Our objective was to determine whether the state operated its managed care program in compliance with the approved state plan waiver.

We reviewed the special terms and conditions (STCs) of the TennCare waiver and determined which ones were applicable for the year ended June 30, 1999. The STCs were discussed with the personnel responsible for compliance, and corroborating evidence, such as reports or other documentation, was reviewed to determine if management had complied with the STCs.

The audit revealed that controls were not adequate to ensure compliance with the STCs of the TennCare waiver, and that management had not complied with all applicable STCs. See finding 25 for more information concerning these matters.

Schedule of Expenditures of Federal Awards

Our objective was to verify that the Schedule of Expenditures of Federal Awards was properly prepared and adequately supported. We verified the grant identification information on the Schedule of Expenditures of Federal Awards prepared by staff in the Division of Budget and Finance, and total reported disbursement amounts were traced to supporting documentation. Based on the testwork performed, we determined that, in all material respects, the Schedule of Expenditures of Federal Awards was properly prepared and adequately supported.

Financial

Our primary objectives were

- to determine if subsidiary records of accounts receivable were properly maintained;
- to determine if the amounts recorded in the State of Tennessee Accounting and Reporting System (STARS) for accounts receivable were adequately supported; and
- to determine if accrued liabilities were adequately supported and properly recorded in STARS.

TennCare's accounts receivable were discussed with the personnel responsible for this function in the Division of Budget and Finance. In addition, reports and other documentation were reviewed to determine the receivable amounts. Significant receivables recorded in STARS were traced to supporting documentation. We compared current year accrued liabilities to prior year amounts and obtained explanations for significant variances. Significant individual amounts were tested for reasonableness and adequacy of support.

Although accrued liabilities appeared to be recorded in STARS correctly in all material respects, testwork revealed that not all accrued liabilities were adequately supported as noted in finding 23. Based upon the testwork performed, it appeared that the amounts recorded in

STARS for accounts receivable were adequately supported and subsidiary records were properly maintained. Our testwork indicated that

- TennCare has failed to collect Medicaid cost settlements from providers (finding 21);
- TennCare has not established adequate overall policies and procedures for accounts receivable (finding 22);
- TennCare does not have adequate policies and procedures for accrued liabilities (finding 23); and
- TennCare committed accounting errors that resulted in a substantial adjustment to the state's financial statements.

TennCare Management Information System General Controls

The primary objectives of this area were:

- to determine if system security and system change procedures were adequate; and
- to determine whether the state Medicaid agency performed the required ADP risk analyses and system security reviews.

To accomplish these objectives, we documented the functions and responsibilities of the Division of Information Services, the information system contractor, and the Office for Information Resources in the Department of Finance and Administration with regard to the TennCare Management Information System (TCMIS). We documented system security and system change and work request procedures, reviewed related reports and manuals, and performed walk-throughs. The requirement for performing ADP risk analysis and system security reviews was discussed with the appropriate personnel.

Detailed testwork was performed to determine the TCMIS transaction screens to which TennCare users had access, and if the system access identification numbers of terminated employees were removed from the system timely.

Testwork revealed that system security needed improvement as noted in finding 17. We determined that system change procedures were adequate. Although TennCare performed the system security reviews, they had not performed and documented the required ADP risk analysis requirements as noted in finding 29. In addition, the TCMIS's lack of flexibility and internal control has been noted in finding 2.

Findings, Recommendations, and Management's Comments

1. Top management must address the TennCare program's numerous and serious administrative and programmatic deficiencies

Finding

Most of the findings in this report are the result of TennCare's numerous administrative and programmatic deficiencies. The March 1999 Performance Audit report also describes many of the program's weaknesses. Well-publicized events concerning the ability of the program to continue in its present form that occurred subsequent to the end of the audit period, June 30, 1999, have contributed to the perception that the program is in crisis.

As discussed in the "Objectives, Methodologies, and Conclusions" section of this report, the auditors are responsible for reporting on the department's internal control and management's compliance with laws and regulations material to the program. Top management is responsible for establishing an effective control environment, which is the foundation for all other components of internal control: risk assessment, control activities, information and communication, and monitoring. Under generally accepted auditing standards, control environment factors include assignment of authority and responsibility; commitment to competence; integrity and ethical values; management's philosophy and operating style; and organization structure.

Our evaluation of the control environment and the other components of internal control revealed several overall, structural deficiencies that have caused or exacerbated many of the program's problems. These deficiencies are discussed below.

TennCare Lacks Stable Leadership

The TennCare program has continued to lack stable leadership. Since the beginning of the program in January 1994, and through December 1999, the program has had four directors and two acting directors. In addition, during the same time there has been significant turnover in the top positions of the program's various divisions, including the Division of Operations, the Division of Budget and Finance, the Division of Quality Improvement, the Division of Policy and Intergovernmental Relations, and the Division of Contract Development and Compliance.

Inadequate System and Staff Resources

As discussed further in finding 2, the TennCare program does not have an adequate information system. Currently the program is dependent upon a large and complex computer system, the TennCare Management Information System (TCMIS), that is outdated and inflexible.

According to management, the TennCare program is understaffed. During fieldwork the auditors noted various efforts to recruit and hire new employees. Another concern is that because of the complexity of the TennCare program (including the laws and regulations that govern the program), long-time employees at the TennCare Bureau possess invaluable knowledge and experience that is difficult to replace when employees retire or leave for other

reasons. For this reason, TennCare needs to focus on plans for retaining key directors, managers, and staff.

The auditors also noted what appears to be a dramatic imbalance in the allocation of staff resources, which appears to reflect top management's priorities as well as the distribution of work. Although the Division of Programs is responsible for numerous programmatic functions, including the provision of special services to children and seriously mentally ill individuals, this division consists only of a director and one other person. In contrast, as of April 1999, there were 39 positions in the Division of Information Services (I/S Division). While it is possible that all of the I/S positions are necessary, it appears that the Division of Programs may lack the resources it needs to adequately perform its duties and responsibilities.

Assignment of Responsibility Concerns

In certain areas of the program, the auditors believe that the assignment of authority and responsibility could be improved. In several areas, the I/S Division is responsible for performing numerous functions beyond the scope of data processing and systems support. This is a concern in terms of which division is most suited or capable of performing the required functions and workload distribution. Because of the numerous and varied responsibilities currently assigned to the I/S Division, management of this division is overburdened and thus less able to focus on system maintenance, development, and support.

For example, as discussed in finding 22, currently the I/S Division is responsible for the premium billing and collection process. Typically the fiscal division accounting department is responsible for these functions. And as described in finding 3, currently the I/S Division is responsible for eligibility functions within the TennCare Bureau, e.g., maintaining a complex eligibility and enrollment database. It might be more appropriate if the TennCare Division of Operations or a newly created and independent Eligibility and Enrollment Unit were responsible for this very important function.

The I/S Division also is responsible for "capturing, maintaining, and reporting encounter data," which is patient data submitted by the managed care organizations and behavioral health organizations. This function may reside more appropriately in the Division of Quality Improvement, which is responsible for gathering and analyzing program statistics.

Last, when obtaining information on the rules and regulations for Medicare cross-over claims, the auditors learned that no one has been assigned the responsibility for 1) being knowledgeable about the rules and regulations for these types of claims or 2) ensuring that these claims are being paid correctly. See finding 16 for more information about the processing and payment of these claims.

The appropriate assignment of responsibility is critical to ensure that all areas of the program are managed effectively and efficiently. Responsibilities should be assigned with regard to training and expertise; proper segregation of duties; and the workload. In addition, policy and program administration management should be the driving force of the TennCare program, not the computer system or the individuals responsible for the system.

Inadequate Written Operating Policies and Procedures

Despite its size and complexity, TennCare does not have adequate written operating policies and procedures. The previous TennCare Director had discussed hiring a consultant to document the program's operating policies and procedures; however, this did not occur.

Inadequate Monitoring

The Bureau of TennCare does not have an on-site internal audit unit, and the Office of Audit and Investigations does not monitor the internal operations of the Bureau. A strong and sizable internal audit presence is critically important given the nature, size, and complexity of the program, and the number of internal control problems that exist.

In addition, in its August 9-12, 1999, site visit report, the Federal Health Care Financing Administration stated

> Although we have brought this to the attention of State officials on multiple occasions, we found that Tennessee has not developed a comprehensive plan for monitoring the TennCare program. Tennessee does have some activities in place for monitoring; however, Tennessee needs a plan that incorporates these activities and any other activities that the State may develop for long-term monitoring for the life of the project (i.e., TennCare). This plan should incorporate the monitoring of the TennCare Partners program.

Recommendation

For the TennCare program to improve and succeed over the long term, the Commissioner and the Acting TennCare Director and his staff must address the problems within and external to the program's administrative structure.

Hiring a new TennCare Director should continue to be one of the Commissioner's top priorities. He or she should also develop a plan to address the program's other personnel requirements. The plan might include cross training, employee development, emphasizing employee career-paths, staff reassignment, workload redistribution, and ways to retain key managers and staff. In addition, the Director should continue to pursue acquisition/development of a new TennCare information system.

The Director should ensure that the assignment of authority and responsibility in all areas is adequate and appropriate. He or she should consider implementing the changes discussed in the finding concerning responsibility for billing and collecting premiums; eligibility and enrollment; capturing, maintaining, and reporting encounter data; and administering Medicare cross-over claims more effectively. In addition, the Director should consider if there are other areas where similar changes should be made.

The Director should ensure that written and comprehensive operating policies and procedures are developed for all areas of the TennCare program. The policies and procedures should be clearly communicated to all program employees, and responsibility for updating the

policies and procedures, as well as distributing the updates, should be assigned to the appropriate staff.

Finally, the Director should develop and implement the comprehensive monitoring plan requested by the grantor. He or she should use the internal auditors to review and monitor the internal operations of the program, particularly the program's extensive and complex automated processes. The internal auditors also could be used to help to implement the monitoring plan or ensure that the plan is being implemented properly by others.

Management's Comment

We concur. While we do concur with the finding recommendation, we do not concur with the implications made by the auditors that the current or the previous management has not addressed the program problems. In previous and in current audit findings, we have addressed the many changes that have either been made for program improvement or have been made due to redirection or enhancement to the program. We all seem to agree that this is a very complex program but we must have cooperation and support, both internally and externally, for the program to continue to succeed. We do acknowledge those areas of concern mentioned in this finding. Management is determined to provide the direction and implement the procedures to stabilize the TennCare Program and ensure the continuity of health care services to the eligible TennCare population. In addition to the major priorities of ensuring the integrity of the program, ensuring consistency in the process of the program with written policies and procedures and ensuring the existence of an emergency plan should a managed care organization fail, the following additional actions have now occurred or are in process: 1) A new Director of Operations has been hired, 2) Enhancements to the eligibility/reverification process are being implemented, 3) An RFP is in process to review current and future system needs, 4) Continuing to search for new director, as well as other critical vacancies in the Program, 5) New Medical Director and a Quality Improvement Director have been hired, 6) In the process of filling 95 new positions that were authorized by the legislature for FY2000.

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2. TennCare Management Information System lacks the necessary flexibility and internal control

Finding

As noted in the prior audit, management of the Bureau of TennCare has not adequately addressed critical information system internal control issues. In addition, the TennCare Management Information System (TCMIS) lacks the flexibility it needs to ensure that the State of Tennessee can continue to run the state's $4 billion federal/state health care reform program effectively and efficiently. Management concurred in part with the prior finding; however, problems continue.

Because of the system's complexity, frequent modifications of the system, and because this system was developed in the 1970s for processing Medicaid claims, TennCare staff and Electronic Data Services (EDS) (the contractor hired to operate and maintain the TCMIS) primarily focus on the critical demands of processing payments to the managed care organizations, behavioral health organizations, and the state's nursing homes rather than developing and enhancing internal control of the system. This has contributed to a number of other findings in this report. These findings indicate that the TennCare Bureau

- has not ensured adequate system security controls related to access were in place during the entire audit period (finding 17);
- has not made payments to certain providers in accordance with the rules (finding 16);
- has not strengthened system controls for Medicare cross-over claims (finding 16);
- made capitation payments for individuals who were not eligible for TennCare (findings 4 and 14);
- incorrectly made payments to the Department of Children's Services for services that should have been provided by behavioral health organizations (finding 4);
- made payments to the Department of Children's Services for individuals over 21 years old (finding 4); and
- made payments to the Department of Children's Services for behavioral health services provided to children under the age of three (finding 4).

Recommendation

The TennCare Bureau should address internal control issues and pursue the acquisition of a system designed for the managed care environment. Until a new system is acquired, the Bureau should continue to strengthen the systems controls to prevent erroneous payments.

Management's Comment

We concur. We agree with the recommendation that the Bureau should pursue the acquisition of a system designed for the managed care environment. The Division of Information Services is currently drafting an Advanced Planning Document (APD) to HCFA requesting enhanced FFP for securing consulting services to assist TennCare in the analysis, definition, design and potential implementation of a new system for TennCare. However, prior to redesign or replacement of the current system, we must have a written business process established. The TennCare Bureau is coordinating strategic business planning effort for the future needs of TennCare. The components of the strategic business plan will be used as the basis for defining a system which will be both flexible as well as functional in maintaining a large and complex system for maintaining managed care.

We also agree that we should continue to strengthen, where possible, the system controls to prevent erroneous payments. The TennCare system has procedures in place to help identify ineligible payments, such as incarcerated youth, deaths, and incarcerated adults. However, the TennCare system must rely on other billing agencies to provide inputs into the system for both payments made to billing agencies and for edit data that determines TennCare eligibility. When this information is updated within the TCMIS, attempts are made to validate the data. Because payments are dependent on this outside information received from the other state agencies and the TCMIS reacts accordingly, internal controls can not eliminate some of the erroneous payments addressed in this finding. Examples include DCS files for payments for children in state custody. Incarcerated youth should not be billed to the TennCare Program. TennCare must rely on DCS data or rely on DCS not to bill for incarcerated youth that are not eligible for the TennCare Program. TennCare must also rely on the Department of Corrections to provide data for those adult inmates that are not eligible for the program. TennCare relies on the Department of Health to provide death records for terminations due to death. Once these data files from other state agencies have been processed, the TennCare system also must follow carefully established procedures for terminating enrollees from the program. In order to prevent the inappropriate termination of an individual, even with data received from these state agencies, other matches must be identified that affirm the accuracy of the termination. When the matches required by the TCMIS system do not occur, a Suspect Report is produced and someone must research the variances before the actual termination can occur. The audit finding also references using Computer-assisted audit techniques (CAATs) to identify capitation payments that have been incorrectly made. Although we may be able to use these CAATs for monitoring our payment process, we would not be able to use these techniques to restrict payments. We will continue to pursue the instances that have been presented in the findings for possible weaknesses in the systems calculation, but TennCare cannot react to outside sources (CAATs) for termination without significant validation of the data.

Auditor's Comment

Management at the Bureau of TennCare is responsible for all expenditures incurred by the Bureau. Management cannot shift this responsibility to others. Instead, management should work with other departments and coordinate efforts to ensure compliance with federal requirements. If necessary, the Director of TennCare should seek assistance from the Administration.

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3. Internal control over TennCare eligibility is not adequate

Finding

The four prior audits of the Bureau of TennCare noted that in many cases, the eligibility of TennCare participants who are classified as uninsured or uninsurable had not been verified.

Management concurred with the prior audit finding, stating that face-to-face enrollment and reverification projects would be implemented to confirm eligibility information onsite. However, verification procedures for initial enrollment and for reverification were still not performed adequately, consistently, or timely. In addition, the Bureau of TennCare does not have a written policies and procedures manual governing enrollment verification and reverification procedures for uninsured and uninsurable enrollees. Furthermore, the Bureau of TennCare has not assigned responsibility for the entire eligibility function to one unit or individual.

For the uninsured and uninsurable population, which makes up approximately 35% of all TennCare enrollees, responsibility for eligibility determination is divided between the county health offices in the Department of Health and the Division of Information Services in the Bureau of TennCare. Because the main purpose of the Division of Information Services is to develop and maintain the TennCare Management Information System, which supports the TennCare program, this division may not be able to effectively and efficiently develop or maintain enrollment procedures.

Furthermore, TennCare does not have a written policies and procedures manual to ensure that TennCare recipients are appropriately and consistently determined to be eligible for TennCare. The county health offices, the Regional Mental Health Institutes, the TennCare Hotline, and the Division of Information Services in the Bureau of TennCare all have the responsibility of determining eligibility for the uninsured and uninsurable population. The different divisions have not been provided with a uniform written policies and procedures manual that would help to ensure appropriate and consistent eligibility criteria.

TennCare's reverification project began in June 1998 and established face-to-face interviews for eligibility updates of enrollees. This project was intended to reverify the eligibility of one-twelfth (1/12) of the entire uninsured and uninsurable population each month. TennCare also relied heavily on updates to the TennCare Management Information System (TCMIS) for reverifying eligibility through data matches and information received from various sources. According to waiver requirements (Special Term and Condition #24), the state must continue to assure that its eligibility determinations are accurate. These reverification procedures, however, did not adequately ensure all TennCare participants were eligible.

Testwork revealed that 115 of 121 uninsured and uninsurable participants (95%) had not had their eligibility information verified or reverified within a year of the date of service. Thirty-two of the 121 files tested (26%) were added to the program within a year of the date of service, which required initial verification of the information on the application. Initial verification includes verifying the applicant's income, social security number, and access to insurance. Of the 32 files requiring initial verification, 27 (84%) had not been verified properly. TennCare could not provide documentation that the enrollees' income and access to health insurance indicated on the application was verified.

The remaining 89 were enrollees who were in the program for more than one year and required reverification of the enrollees' information. Reverification includes obtaining current information about the enrollees' income and access to insurance. For 88 of the 89 (99%), the

enrollee's eligibility information had not been reverified within a year prior to the date of service. Further testwork revealed that 25 of the 88 were reverified subsequent to the date of service and subsequent to the year ended June 30, 1999. The remaining 64 enrollees had not been reverified (as of November 10, 1999) according to the TennCare system. The total amount of capitation improperly paid for the errors noted above was $12,435.88 out of a total of $12,789.96 tested. Federal questioned costs totaled $7,854.19. An additional $4,581.69 of state matching funds was related to the federal questioned costs. We believe likely questioned costs would exceed $10,000.

Furthermore, using computer-assisted audit techniques to search the TennCare Management Information System (TCMIS), auditors found 115 TennCare participants had "pseudo social security numbers," e.g., numbers that began with 8 or had all zeros in one field. According to TennCare personnel, some applicants who do not have their social security cards and/or newborns who have not yet been issued social security numbers are assigned these "pseudo" numbers. Management stated in response to the prior finding that TennCare strives to provide needed care to children as soon as possible and that the reverification project would help ensure that valid numbers are obtained after enrollment.

Testwork revealed that 68 of 115 individuals (59%) found with "pseudo" social security numbers had not had a correct social security number entered on TCMIS, although they were enrolled more than a year earlier. Some of these TennCare participants had been enrolled in the Medicaid program as early as 1980. Also, while it is not always possible to obtain social security information for newborns (0-3 months), auditors noted that several individuals with pseudo social security numbers were over one year old.

According to the *Code of Federal Regulations*, Title 42, Part 435, Section 910, the state agency must require, as a condition of eligibility, that those requesting services (including children) provide social security numbers. Additionally, Section 3(g) of the Code states that the agency "must verify the social security number of each applicant and recipient with the Social Security Administration, as prescribed by the Commissioner, to ensure that each social security number furnished was issued to that individual, and to determine whether any others were issued."

Adequate verification procedures are needed to ensure that only those eligible are enrolled in TennCare. According to Office of Management and Budget Circular A-133, payments are only allowed for individuals who are eligible for the TennCare/Medicaid program. For the year ended June 30, 1999, the Bureau paid capitation payments totaling approximately $1,873,069,128 to MCOs and $343,959,092 to BHOs for TennCare enrollees, which includes approximate capitation payments for the uninsured and uninsurable population of $654,075,739 and $120,110,515, respectively.

Annual reverification is also necessary to obtain current, accurate information about family size, income, Tennessee residency, and access to other insurance. This information is needed to determine whether participants previously considered eligible have become ineligible because of changes in their family or personal circumstances. Also, this information is used to determine the correct premium and deductible amounts paid by participants.

Recommendation

The Director of TennCare should promptly develop and implement adequate uniform procedures to ensure that the eligibility status of all TennCare recipients is determined properly, consistently, and timely. Bureau Management should consider establishing a unit to oversee the eligibility function. The Director should also develop a written policies and procedures manual and ensure that all divisions involved in the enrollment process of the uninsured and uninsurable population are provided with the manual to ensure eligibility criteria is applied to the TennCare recipients consistently and accurately.

Management's Comment

We concur. The reverification process that began in June of 1998 has resulted in the reverification of 145,006 enrollees as of January 2000. This represents approximately 28% percent of the current TennCare non-Medicaid population and is consistent with the audit finding of 24 out of 88 cases reverified subsequent to the date of service and subsequent to the year ended June 30. Another approximately 28% are enrollees who have not been in the program for one year. The current reverification process is a process that is verifying enrollees that are past due (enrolled for >12 1months) for the annual reverification. In order to facilitate the completion of past due cases and move to the desired annual reverification, the Bureau of TennCare appointed a reverification task force. The task force was appointed in January 2000 in order to identify deficiencies, improve the reverification process and to address previous audit finding. The task force is lead by an outside consultant has been given the authority to make necessary changes and ensure appropriate systems are in place to address this repeat audit finding. The task force includes individuals from all government departments involved in enrollee eligibility verification, including Department of Human Services, Department of Mental Health and Mental Retardation, Department of Health Services and Bureau of TennCare. The goals of the task force are: 1) Initiate the process for reverification on each case/enrollee in the non-Medicaid population. 2) Terminate enrollees that are no longer eligible. 3) Build credibility in the reverification process. 4) Identify and develop procedures to include cases that are currently excluded from reverification. 5) Identify and develop procedures to deal with cases that remain indefinitely in various stages of the process. 6) Improve enrollee education concerning TennCare. 7) Ensure accuracy of enrollee information. 8) Develop tracking and audit mechanisms to ensure efficacy of the reverification process. 9) Document policies and procedures related to reverification of non-Medicaid enrollees. The task force has initiated changes that allowed inclusion of 600 cases in the February 2000 reverification selection that had not previously completed the process. In addition the task force is testing an electronic database to expedite locating forwarding addresses for enrollees. The intent of the task force is to include in the March 2000 selection the bulk of the remaining past due reverifications. Reports addressing findings and results realized from the task force directives are given directly to top management.

4. Because communication between TennCare and Children's Services has been inadequate, TennCare incorrectly reimbursed the Department of Children's Services over $9 million for services covered by the Behavioral Health Organizations, services that were unallowable, services inadequately documented, or services not performed

Finding

TennCare has paid the Department of Children's Services (Children's Services) for services that were outside the scope of its agreement with the Bureau of TennCare during the year ended June 30, 1999. In accordance with its agreement with TennCare, Children's Services contracts separately with various practitioners and entities (service providers) to provide Medicaid services not covered by the managed care organizations (MCOs) and the behavioral health organizations (BHOs) that are also under contract with TennCare. Children's Services pays these service providers for Medicaid services (enhanced behavioral health services) and non-Medicaid services (housing, meals, and education) directly. Children's Services then should bill TennCare for the reimbursement of only the Medicaid services. During the year ended June 30, 1999, TennCare paid approximately $103 million in fee-for-service reimbursement claims to Children's Services.

TennCare has not adequately defined and communicated the specific Medicaid/TennCare services it is requesting from Children's Services. In addition, TennCare has not communicated the specific laws and regulations that Children's Services must follow. Testwork revealed the following deficiencies:

Payments for Incarcerated Youth

As noted in the prior two audits, TennCare has not identified incarcerated youth enrolled in the program, and has paid for the health care costs of youth in the state's youth development centers and detention centers. Under federal regulations (*Code of Federal Regulations*, Title 42, Section 435, Subsections 1008 and 1009), the state, not the federal government, is responsible for the health care costs of juvenile and adult inmates. Management concurred with the prior finding, stating that the TennCare staff had met with Children's Services on this subject and would utilize the monitoring agreement with the Department of Finance and Administration (F&A) to examine internal controls over this area. In addition, management stated that TennCare would pursue implementing computer-assisted monitoring techniques similar to the ones used by the auditors for detecting incarcerated youth. Although TennCare's management contracted with F&A to examine this area, TennCare still does not have adequate controls and procedures in place to prevent these types of payments (see finding 7).

Using computer-assisted audit techniques (CAATs), a search by the auditors of TennCare's paid claims records revealed that TennCare made payments totaling $2,871,075.03 for the year ended June 30, 1999, for juveniles in the youth development centers and detention centers. Of this amount, $656,519.26 was paid to MCOs, $242,258.95 was paid to BHOs, and

$1,972,296.82, to Children's Services. Federal questioned costs totaled $1,660,294.52. An additional $968,521.56 of state matching funds was related to the federal questioned costs.

BHOs are not to be reimbursed for costs associated with incarcerated youth. The total payments to the two BHOs are based on a predetermined budget for mental health services approved by the Health Care Financing Administration (HCFA). These payments are allocated between the BHOs based on the number of eligible clients. Eligibility includes not being incarcerated. When a BHO has included ineligible clients in its population of TennCare eligible clients, the portion of the money budgeted for that BHO should be reduced to that extent and awarded to the other BHO. The total amount paid to the BHOs is not affected. Thus, the total amount paid to the BHOs is not a questioned cost in this audit.

Although the total amount paid to the BHOs is not affected, future funding might be affected. When ineligible individuals are included in the population, the population is skewed and could affect assumptions made when determining the amount of the global budget paid to the BHOs in the future.

The payments to the MCOs were monthly capitation payments—payments to managed care organizations to cover TennCare enrollees in their plans. Since the bureau was not aware of the ineligible status of the children in the youth development and detention centers, TennCare incorrectly made capitation payments to the MCOs on their behalf.

Payments for Children on Runaway Status

TennCare has paid for enhanced behavioral health services for children who are in the state's custody but are on runaway status. No services were performed for these children because they have run away from the service providers. According to the Office of Management and Budget (OMB) Circular A-133, to be allowable, Medicaid costs for services must be for an allowable service that was actually provided. *Code of Federal Regulations*, Title 42, Part 1003, Section 102, prohibits billing for services not rendered.

It is the responsibility of Children's Services to notify TennCare when children run away from service providers. Testwork revealed Children's Services does not notify TennCare when children are on runaway status. Children's Services' provider policy manual allows service providers to bill Children's Services for up to 10 days for children on runaway status, but Children's Services cannot bill TennCare for those days. Since the Bureau has no routine procedures, such as data matching, to check for such an eventuality, it was unaware Children's Services was reimbursed for treatment costs that were not incurred by the service providers.

Using CAATs, auditors performed a data match comparing TennCare's payment data to runaway records from Children's Services Client Operation and Review System (CORS). Management at Children's Services has indicated the CORS records are not reliable; however, as of December 10, 1999, Children's Services has not provided the auditors with evidence that would indicate the runaway records were incorrect. The results of the data match indicated that TennCare had improperly paid $403,653.63 the for year ended June 30, 1999, to Children's Services for children on runaway status. Federal questioned costs totaled $254,937.54. An additional $148,716.09 of state matching funds was related to the federal questioned costs.

Payments for Individuals Over 21

TennCare does not have procedures to identify the TennCare eligible individuals who have reached the age of 22, and therefore cannot stop payments to Children's Services for Medicaid services provided to these individuals who are older than 21 years. In accordance with the TennCare waiver and the State Plan, Children's Services should bill and receive reimbursement from TennCare only for Medicaid services provided to recipients in its care who are 21 years or under.

TennCare contracts with Children's Services to determine the eligibility of children under its care and should notify TennCare when an individual is older than 21 years. However, Children's Services does not notify TennCare when an individual reaches the age of 22. Since the Bureau has no routine procedures to check for such an eventuality, it was unaware Children's Services billed for recipients who were older than 21 years. When the recipient is over 21 years of age, the recipient may receive TennCare services through the MCOs, BHOs, or other departments, but not through Children's Services.

Using CAATs, a search by the auditors of TennCare's paid claims records revealed that TennCare improperly paid a total of $77,347.37 for the year ended June 30, 1999, for individuals over 21. Federal questioned costs totaled $48,850.67. An additional $28,496.70 of state matching funds was related to the federal questioned costs.

TennCare Paid Children's Services for Services Covered by the BHOs

When TennCare began (January 1, 1994), TennCare contracted with Children's Services to provide all behavioral treatment for children in state custody or at risk of state custody. On July 1, 1996, TennCare contracted with the BHOs to provide some behavioral health treatment for children in state custody or at risk of state custody. However, the TennCare waiver was not amended to define the responsibilities of Children's Services.

TennCare contracts with the BHOs to provide the basic and enhanced behavioral health services for children not in state custody as well as basic behavioral health services for children in state custody. In addition, TennCare has contracted with the BHOs to provide all services to prevent children from entering state custody (Hometies) for children at risk of state custody. All behavioral services for children not in state custody should be provided through the TennCare BHOs. Enhanced behavioral health services for children in state custody should be provided by Children's Services. Since TennCare does not have procedures to identify services covered by the BHOs for children in state custody or at risk of state custody, TennCare has paid both the BHOs and Children's Services for the following services:

- TennCare has made payments to Children's Services for enhanced behavioral health services for children not in state custody. Using CAATs, auditors performed a data match comparing payment data on the Bureau of TennCare's system to custody records from Children's Services CORS system. The results of the data match indicated that TennCare had improperly paid $4,647,493.79 for the year ended June 30, 1999, for children who were not in the state's custody. Management at Children's Services indicated that the CORS system was not reliable and that the children could

possibly be in the state's custody. As of December 10, 1999, Children's Services had not provided the auditors with evidence that would support the custodial status of the children in question. A portion of these improper amounts (see below for further discussion) was paid for services to prevent children from entering state custody, also known as the Hometies Program in Children's Services, which is covered by the BHOs. Federal questioned costs, excluding $1,411,028.51, which is included in the Hometies amount questioned below, totaled $2,044,070.56. An additional $1,192,394.72 of state matching funds was related to the federal questioned costs.

- TennCare has made payments to Children's Services for Hometies services provided to children at risk of state custody. TennCare improperly paid Children's Services $2,279,293.00 for the year ended June 30, 1999, for services covered by the BHOs. Federal questioned costs totaled $1,439,544.48. An additional $839,748.52 of state matching funds was related to the federal questioned costs.

Payments for Services Provided to Children Under Three Years

TennCare has paid Children's Services for behavioral health services provided to children under three years old. Based on discussion with TennCare's medical staff, a child cannot be mentally evaluated until the age of three. Since very young children cannot be mentally evaluated, it does not seem reasonable that these children received these types of Medicaid services. Management at Children's Services cited the following as possible reasons this occurred:

- Children's Services billed in the child's name for services actually rendered to the child's mother. However, this is inappropriate because TennCare has not received approval from HCFA to allow this type of indirect billing. By allowing this type of indirect billing, it is possible the service provider was paid twice for services provided to the mother.

- Children's Services billed for children under age three who are medically fragile. However, the MCOs are responsible for providing all medical treatment to these TennCare enrollees.

Using CAATs, a search by the auditors of TennCare's paid claims records revealed that TennCare improperly paid a total of $1,673,100.41 for the year ended June 30, 1999, for children under three. Federal questioned costs totaled $1,056,688.39. An additional $616,412.02 of state matching funds was related to the federal questioned costs.

Payments to Children's Services for Claims That Were Not Adequately Supported

For 12 of 60 claims tested (20%), TennCare inappropriately reimbursed Children's Services for billings when there was inadequate evidence that the child received the service. OMB Circular A-87 requires all costs to be adequately documented.

A total of $2,838.05 was paid for these services. Federal questioned costs totaled $1,792.44. An additional $1,045.61 of state matching funds was related to the federal questioned

costs. We believe that likely federal questioned costs associated with this condition could exceed $10,000.

Our review of the files associated with custody, runaways, incarcerated youth, individuals over 21, vendor billings, children under three, and children in the Hometies program revealed that there was some duplication of questioned costs. We estimate the amount of duplicated questioned costs to be $250,000.

In total, $9,644,994.56 was improperly paid to Children's Services, $656,519.26 to the MCOs, and $242,258.95 to the BHOs. As discussed earlier, the amounts paid to the BHOs will not be questioned. A total of $6,506,178.60 of federal questioned costs is associated with the conditions discussed in this finding. An additional $3,795,335.22 of state matching funds was related to the federal questioned costs.

Recommendation

The Director of TennCare should ensure computer-assisted monitoring techniques are developed by the Bureau to prevent or detect payments for incarcerated youth, children on runaway status, individuals over 21, services covered by the BHOs, and children under three. The Director of TennCare should ensure Children's Services bills only for recipients who receive services and are eligible to receive services. Management should also consider whether any action is necessary regarding the monthly allocation of funds between the BHOs. An accurate population of eligible BHO clients should be determined for purposes of future monitoring. In addition, the Director of TennCare should ensure Children's Services is immediately notified of all relevant laws and regulations. Also, the Director of TennCare should ensure Children's Services is appropriately notified of which services the BHOs are responsible for and which services would fall to Children's Services. The Director of TennCare should also ensure TennCare's management communicates effectively with Children's Services to ensure timely resolution of the numerous problems noted.

Management's Comment

We concur. TennCare will review the services provided by the BHOs in relation to those services provided by DCS and will work with DCS to ensure their knowledge of those services that can be billed to TennCare and those that must be billed to the BHOs. TennCare will continue to work with DCS to determine the cause and resolution necessary to resolve problems addressed with this program. TennCare will address monitoring techniques that may be available to help detect or prevent unauthorized payments for children in state custody or at risk of coming to state custody.

5. TennCare should ensure the Department of Children's Services payment rates are reasonable and have been approved by the Health Care Financing Administration

Finding

As noted in a previous audit finding, with which management concurred, TennCare has not ensured the Department of Children's Services (Children's Services) has established federally approved Medicaid treatment rates for services provided for children in state custody. TennCare has relied on Children's Services to determine the Medicaid treatment rates paid to the Medicaid service providers for children in the state's custody. Children's Services pays the Medicaid service providers for all Medicaid (treatment) and non-Medicaid services (housing, meals, and education) directly, then bills TennCare for the reimbursement of Medicaid services.

Management of Children's Services could not provide information as to how the treatment portion of services was determined. Management of Children's Services concurred in part with the previous finding in their report and stated they would perform a study to address the problem. Although a study has been performed, Children's Services has not implemented the new rates as of December 10, 1999. Without an understandable methodology to determine the true treatment costs incurred by the Medicaid service providers, Children's Services may be over- or underbilling TennCare for costs associated with the treatment. In addition, TennCare may be reimbursing Children's Services for non-Medicaid services. Because actual treatment costs could not be determined and differentiated from unallowable costs, auditors could not determine the amounts of possible overbillings and unallowable costs paid by the federal government. Since management at Children's Services could not explain the current methodology, it is unlikely the current rates meet Medicaid principles.

Recommendation

The Director of TennCare should ensure that Children's Services implements a federally approved methodology that is in compliance with Medicaid principles for treatment costs associated with children in state custody. If the Director of TennCare cannot persuade Children's Services to comply, the Director of TennCare should seek the assistance of the Commissioner of Finance and Administration in seeking Children's Services' compliance with federal regulations.

Management's Comment

We concur. The Bureau of TennCare is working with DCS in getting a revised federally approved payment methodology for children's therapeutic intervention services that is in compliance with Medicaid principles and Medicaid/Title V Agreement relative to children in state custody.

Auditor's Comment

The Medicaid/Title V agreement referenced above is not relevant to the current program because it was not updated to reflect the changes in the state Medicaid plan and the expanded services for children in state custody under the current TennCare waiver. In addition, neither TennCare nor Children's Services performs Title V services.

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6. TennCare should continue to seek written approval and clarification of grant requirements

Finding

As noted in the prior three audits, modifications to TennCare's grant requirements are often necessary because TennCare is a relatively new approach to Medicaid for both the state and the Health Care Financing Administration (HCFA). However, the intent of some requirements becomes unclear with the changes. The payment rates for certain psychiatric services is one such case. Although management concurred with the prior findings and stated that they contacted HCFA officials and are awaiting response, no evidence of this contact has been provided.

When TennCare began, mental health services were not immediately moved into a managed care setting as were other health services. As a result, the state requested permission from HCFA to continue to pay for some mental health services on a fee-for-service basis. The November 18, 1994, approval letter from HCFA states:

> For both the Children's Plan [Department of Children's Services] and the SPMI [severely and persistently mentally ill], retroactive payments to January 1, 1994, will be permitted on a fee-for-service (FFS) basis, subject to the State's processing these claims through the State Medicaid Management Information System that was in place prior to January 1, 1994, at the previously existing rates. [emphasis added]

Without seeking guidance from HCFA, TennCare interpreted this waiver as allowing the state to continue to adjust for inflation the SPMI and the Department of Children's Services (Children's Services) rates for psychiatric hospitals and community mental health centers as it had done under Medicaid. During the year ended June 30, 1995, TennCare also adjusted these rates to cover additional costs, such as capitalization of fixed assets and property taxes, and enhanced the rates by a Medicaid "disproportionate share factor" to help cover hospital charity costs. Prior to TennCare, these costs and the disproportionate share factor were not a part of the rates.

On July 1, 1996, TennCare implemented the TennCare Partners Program to provide mental health services in a managed care setting and discontinued fee-for-service payments for SPMI. However, Children's Services continues to pay with the higher adjusted rates on a fee-for-service basis. Since TennCare is using the higher adjusted rates, then both the state and the federal government are paying more than has been approved by the waiver.

Although management agreed that all policies and programs and resulting payments should comply with grant requirements, management has not obtained documentation from HCFA regarding its position on the adjusted rates. During audit fieldwork, the Fiscal Director of TennCare stated that HCFA had verbally approved the adjusted rates. As of October 19, 1999, TennCare has not received the approval letter from HCFA.

Recommendation

The Director of TennCare should immediately follow up with HCFA to obtain formal written approval for the adjusted rates. The Director of TennCare should also ensure that all policies or programs and resulting payments comply with grant requirements. If these requirements are unclear or if a substantial change is made, TennCare should seek written approval from the grantor before implementing the change.

Management's Comment

We concur. TennCare has requested written response from HCFA. As of the date of this response, we have not received the written response.

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7. TennCare has not adequately monitored TennCare-related activities at the Department of Children's Services

Finding

As noted in the prior two audits, TennCare has not adequately monitored the Department of Children's Services (Children's Services). Management concurred with the finding and contracted with the Department of Finance and Administration (F&A) to monitor several aspects of Children's Services' operations for the year ended June 30, 1999. Although TennCare recognized the need for a strong monitoring effort and has contracted with F&A to provide this service, the monitoring effort still needs improvement. In addition, TennCare did not inform F&A of all compliance issues, regulations, and guidelines that should be monitored.

In accordance with the agreement between Children's Services and TennCare, Children's Services contracts separately with various practitioners and service providers to provide health care benefits not provided by the managed care organizations (MCOs) and the behavioral health

organizations (BHOs) under contract with TennCare. Children's Services pays these providers and bills TennCare for reimbursement. For the year ended June 30, 1999, TennCare paid approximately $103 million to Children's Services in fee-for-service reimbursement claims.

TennCare's monitoring through a memorandum of understanding (MOU) with F&A includes efforts to ensure that

- only services allowable under the grant are billed;
- the amounts billed are correct and allowable;
- the expenditures are valid and properly supported; and
- only eligible, licensed, or certified providers are providing the services.

F&A reviewed only one out of 12 months for allowability of payments. One month of testing does not provide reasonable assurance that all services billed TennCare were allowable. In addition, F&A did not follow the MOU's requirements related to monitoring of the following critical areas:

- F&A did not test the accuracy of Children's Services billing rates (finding 5).
- F&A did not test the eligibility determinations to ensure that only eligible individuals are enrolled in TennCare.
- F&A did not determine if procedures existed to identify incarcerated youth. Claims associated with incarcerated youth cannot be billed to TennCare.
- F&A did not test the providers to ensure all provider enrollment qualifications were met.
- Based on numerous discussions with F&A monitoring staff, it was apparent that F&A was not aware of all possible unallowable costs associated with Children's Services' claims including runaway days, payments for noncustodial children, and services that were covered by the behavioral health organizations (BHOs) for children in state custody (finding 4).

Recommendation

The Director of TennCare should ensure F&A properly performs its responsibilities under the monitoring agreement. TennCare should consider all critical areas of compliance, especially related to Children's Services' billings for ineligible services or children. These areas and the applicable compliance requirements should be appropriately included in the monitoring agreement with the Department of Finance and Administration.

Management's Comment

We concur. The Bureau of TennCare has enhanced the scope of services required in the monitoring plan with the Department of Finance & Administration for the current fiscal year. We will work with F&A monitoring staff to ensure their knowledge of allowable and unallowable services.

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8. TennCare has delegated authority to the Division of Mental Retardation Services in the Department of Finance and Administration to determine eligibility for and to have administrative discretion over the Medicaid Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled

Finding

TennCare has delegated authority for eligibility determinations and authority to exercise administrative discretion for the Medicaid Home and Community Based Services (HCBS) Waiver to the Division of Mental Retardation Services (DMR) in the Department of Finance and Administration. As provided under Section 1902(a)(5) of the Social Security Act, the Department of Health (including the TennCare Bureau) is the state's designated single state agency for the Medicaid program. The *Code of Federal Regulations* (CFR), Title 42, Part 431, Section 10, requires the single state Medicaid agency to determine eligibility for the disabled. However, the TennCare Bureau has allowed DMR to determine the eligibility of recipients under the HCBS waiver. The eligibility function performed by DMR includes all approval functions for those recipients deemed eligible.

The CFR, Title 42, Part 431, Section 10, states that in order for an agency to qualify as the Medicaid agency, the following must exist:

> (1) The agency must not delegate, to other than its own officials, authority to (i) Exercise administrative discretion in the administration or supervision of the plan, or (ii) Issue policies, rules, and regulations on program matters.
>
> (2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the state.
>
> (3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

Testwork revealed that TennCare has not maintained its authority over the HCBS waiver. For example, TennCare has not issued specific policies and procedures for the waiver program, and has allowed DMR to develop procedures for the program without TennCare's oversight and supervision. Furthermore, DMR developed policies without regard to Medicaid rules.

In addition, TennCare's monitoring of the program has not been adequate to provide sufficient supervision of the program. See finding 9 for information concerning monitoring. Also, DMR has developed a payment methodology that appears to contradict specific requirements of a Health Care Financing Administration (HCFA) Transmittal letter stating leave days are not allowable under the Medicaid program for home and community based services. See finding 11 for further information concerning this payment methodology. DMR's current payment methodology results in TennCare ultimately paying for services under the waiver that exceed actual costs of the services provided, which is unallowable under Office of Management and Budget Circular A-87*, Cost Principles for State, Local, and Indian Tribal Governments*.

Without adequate authority, supervision, and effective monitoring of the HCBS waiver, TennCare cannot ensure that all applicable federal regulations are met and that appropriate costs are passed on to the federal grantor.

Recommendation

The Director of TennCare should establish TennCare's authority over the waiver program and not permit DMR administrative discretion over the waiver. The Director of TennCare should develop policies and procedures, and appropriate rules for the waiver. If eligibility determinations are to continue under DMR, then TennCare should perform the approval function for eligibility. Adequate monitoring of the waiver should be performed by TennCare to allow adequate supervision of administrative functions performed by DMR for the waiver.

Management's Comment

We partially concur. We continue to disagree with the audit report's interpretation of Medicaid requirements as stated below. TennCare hasn't improperly delegated authority to the Division of Mental Retardation Services (DMRS). TennCare has appropriate interagency agreements with DMRS under which DMRS performs specified functions for TennCare. Although DMR has policies and procedures in place for the HCBS Waiver, we do recognize that improvements and updates are necessary and that TennCare should have an approval role in the process. We also recognize that TennCare needs to strengthen its own policies, procedures and rules relative to this waiver. TennCare fully recognizes its responsibility to supervise and monitor the waiver program. We agree that our monitoring efforts must be improved and will review the current process for necessary changes. We do not concur relative to the delegation of eligibility determination to DMRS. DMRS makes no Medicaid financial eligibility determinations, which is performed by the Department of Human Services. DMRS does perform pre-admission clinical evaluations for DMRS waiver clients but we feel HCFA allows this and will confirm our understanding.

Rebuttal

TennCare has delegated authority to DMR. The requirements set forth for the single state Medicaid agency in the *Code of Federal Regulations* (CFR) are very specific. The single state Medicaid agency may not delegate administrative discretion or allow others to issue policies, rules, and regulations on program matters. TennCare has allowed DMR to issue policies and procedures concerning the HCBS waiver program without TennCare approval. In allowing DMR to create its own policies and procedures without TennCare approval, TennCare is not in compliance with CFR, Title 42, Part 431, Section 10, requirements. In addition, DMR substituted its own judgment in devising a claims payment system not in compliance with federal requirements.

TennCare concurred with a finding concerning TennCare's inadequate monitoring of the program. Monitoring of DMR would have allowed TennCare to adequately supervise DMR's administration of the HCBS waiver.

Furthermore, the single state Medicaid agency is responsible for eligibility determinations in the Medicaid program; however, the state agency responsible for SSI determination under the CFR may also make Medicaid financial eligibility determinations. The Department of Human Services is the state agency responsible for Medicaid financial eligibility determinations in the state of Tennessee. Entry into areas of the Medicaid program requiring medical determination to receive specific Medicaid services for disability would still require determination of the single state Medicaid agency.

The HCBS waiver has eligibility requirements for medical necessity beyond those of the regular Medicaid program. As well as meeting standard Medicaid requirements, the recipient must be mentally retarded and developmentally disabled. CFR, Title 42, Part 431, Section 10, requirements specifically state the types of agencies that can determine disability. DMR is not one of the types of agencies listed.

TennCare's Long Term Care unit determines eligibility for all other long-term care services offered under the state Medicaid plan. The other long-term care services include services for home and community based waivers for elder and disabled care, skilled nursing and intermediate care services for the elderly and disabled, and intermediate care services for the mentally retarded and developmentally disabled. These other long-term care options require eligibility determinations beyond Medicaid eligibility to obtain Medicaid long-term care services. Clearly all eligibility determinations for the long-term care services should remain with the TennCare program, as the single state Medicaid agency, to remain in compliance with the provisions of CFR, Title 42, Part 431, Section 10, concerning determination of disability.

9. TennCare's monitoring of the Medicaid Waiver for Home and Community Based Services for the Mentally Retarded has not been adequate

Finding

The TennCare Bureau's monitoring of the Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled under Section 1915(c) of the Social Security Act (HCBS waiver) is inadequate to provide the federally required assurances of health and welfare and of financial accountability. TennCare has not developed a formal monitoring plan (including the necessary policies and procedures) to ensure all the required areas are adequately monitored and other procedures are performed to provide the required federal assurances. TennCare has not reported the required assurances in a timely manner nor adequately documented the support for the health, welfare, and financial accountability section of the report. Furthermore, TennCare has not performed adequate monitoring of the Division of Mental Retardation Services (DMR) in the Department of Finance and Administration, which oversees the program for TennCare and is contractually required to monitor the HCBS waiver's Medicaid service providers. (See finding 10 for information concerning DMR's monitoring activities.)

Section 1915(c)(2)(A) of the Social Security Act requires that

> necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds with respect to such services.

The Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Waiver requires TennCare, the single state Medicaid agency, to have a formal plan of monitoring in place to ensure the health and welfare of individuals on the waiver. TennCare further assures that all problems identified by the monitoring process will be addressed in an appropriate and timely manner, consistent with the severity and nature of deficiencies. This monitoring process is also intended to support required assurances of health and welfare. The HCBS waiver also requires TennCare to provide assurances of financial accountability for funds expended for home and community based services provided under the State Medicaid Plan. The monitoring plan must include filing the required federal reports.

TennCare does not appear to have adequate personnel to perform the monitoring needed to support the federally required assurances. The TennCare Bureau had one monitor for the 4,315 recipients of waiver services, 330 service providers, and DMR during the year ended June 30, 1999. The one monitor was a registered nurse. No fiscal personnel were provided to perform fiscal monitoring for assurance of financial accountability.

Section 1915(c)(2)(E) of the Social Security Act requires the state to provide the Secretary of the Department of Health and Human Services (HHS) with an annual report, the Health Care Financing Administration (HCFA) 372 report, on the impact of the Mental Retardation Home and Community Based Services Waiver (HCBS waiver) on the type and amount of medical assistance provided under the state plan and on the health and welfare of the recipients, including TennCare's assurances of health and welfare and of financial accountability under the waiver.

For the years ended June 30, 1998, and June 30, 1997, TennCare has not submitted the HCFA 372 Report within 181 days after the last day of the waiver period as required by the HCFA *State Medicaid Manual* Section 2700.6 E. Submittal Procedures for Due Date. The reports were 57 days and 230 days late, respectively. In addition, TennCare could not provide adequate documentation to support the health and welfare information in the HCFA 372 report. Without adequate documentation of the work performed in the monitoring process, auditors could not determine if monitoring was adequate to support health and welfare assurances and to support financial accountability assurances in the report.

Furthermore, TennCare has not performed adequate monitoring of the waiver. The contract between the Tennessee Department of Health (TDH) and DMR allows DMR to administer the HCBS waiver under the supervision of TennCare. While TennCare has no formal monitoring policies and procedures, TennCare does have monitoring responsibilities for the HCBS waiver in its contract with DMR. The contract specifically includes the following responsibilities for TennCare:

1. TennCare is to review a random sample of Preadmission Evaluations prepared by DMR during the annual state assessment period. TennCare has not performed this review during the contract period.

2. TennCare is to monitor the plan of care for persons receiving waiver services by reviewing a sample of the plans of care for recipients in the program during the state assessment. Testwork revealed that the TennCare monitoring staff did monitor plans of care during the annual state assessment period.

3. TennCare is required to monitor the DMR's policies for implementation and coordination of the waiver services approved by HHS. However, TennCare has not monitored DMR's implementation and coordination of the waiver services.

4. Per the contract, TennCare is to provide quality assurance monitoring to evaluate performance of the DMR. However, TennCare has not performed adequate quality assurance monitoring of DMR.

5. TennCare is to perform periodic audits of client records to validate the findings of the DMR Quality Enhancement review, and report the results to DMR with action required or needed to rectify deficiencies in a timely manner. This report is an annual statewide assessment of DMR's overall performance in the waiver. TennCare has no mechanism to perform audits of client records. Furthermore, TennCare has not

provided DMR with timely statewide assessment reports. Statewide assessment reports for years ending June 30, 1996, and June 30, 1995, were not submitted to DMR for action until November 3, 1998. The statewide assessment reports performed for years ending June 30, 1998, and June 30, 1997, have not been submitted to DMR as of December 10, 1999.

6. TennCare is to assure the health and welfare of the individuals served in the waiver, through monitoring of quality control procedures described in the Medicaid Home and Community Based Services Waiver for the Mentally Retarded and Developmentally Disabled. TennCare does not have adequate documentation to indicate this was performed.

Only one of the six responsibilities has been fulfilled. In addition, these contractual requirements do not include specific responsibility for assurances of financial accountability. As a result, TennCare cannot support the required federal assurances for health and welfare and for financial accountability. Also, TennCare's inadequate monitoring increases the risk that federal requirements are not met.

Recommendation

The Director of TennCare should develop waiver monitoring policies and procedures to ensure a formal monitoring plan exists to provide the required health and welfare and financial accountability assurances to HCFA. The Director should ensure that the HCFA 372 reports and contractually required reports are submitted in a timely manner. The Director should monitor the process to ensure adequate assurances of health and welfare and of financial accountability are made to HCFA. The Director should ensure an adequate number of appropriately trained staff is available to perform monitoring.

Management's Comment

We concur. Efforts will be made to ensure timely submission of the HCFA 372 Reports and the timely submission of monitoring reports as required in the inter-agency agreement. TennCare will update policies and procedures for monitoring the HCBS Waiver and will evaluate staffing resources in this area or other monitoring options that may be available.

10. TennCare should ensure the Division of Mental Retardation Services in the Department of Finance and Administration provides adequate monitoring of the Medicaid Home and Community Based Services

Finding

The TennCare Bureau did not ensure that the Division of Mental Retardation Services (DMR) complied with its contract monitoring requirements for the Medicaid Home and Community Based Services (HCBS) for the Mentally Retarded and Developmentally Disabled waiver. The contract between the TennCare Bureau and DMR requires DMR to give assurance that necessary safeguards will be taken to protect the health and welfare of the recipients of home and community based services and assurance of financial accountability for funds expended for home and community based services.

Testwork revealed that DMR is adequately monitoring to ensure that the traditional long-term care providers have the necessary safeguards in place to protect the health and welfare of waiver recipients. However, testwork revealed that DMR has not adequately monitored the waiver's alternative providers. Alternative providers are home health agencies and individual providers such as dentists, behavioral therapists, nutritionists, physical therapists, etc.

In addition, DMR is not providing necessary assurance of financial accountability for funds expended for all providers. Furthermore, DMR's current monitoring policies have not been revised to include the monitoring process for the alternative providers and do not include the fiscal monitoring process for the financial accountability assurances.

DMR relies on programmatic personnel at the regional offices to perform monitoring for health and welfare assurances of the traditional long-term care providers. DMR and the Department of Mental Health and Mental Retardation share responsibility for fiscal monitoring. Although fiscal monitors were employed for the Middle Tennessee Regional Office – Nashville and in the East Tennessee Regional Office – Knoxville during the year ended June 30, 1999, the West Tennessee Regional Office – Memphis did not have a fiscal monitor during this period. During June 1999, the fiscal monitor at the Middle Tennessee Regional Office left, leaving this position vacant. In the absence of fiscal monitors, DMR programmatic monitors have performed fiscal monitoring tasks; however, on a statewide basis, monitoring may not be effective for financial accountability because the programmatic staff performing fiscal monitoring may not be adequately trained to perform fiscal monitoring.

Furthermore, the Middle and West Tennessee Regional offices did not maintain back-up documentation for fiscal monitoring activities and the West Tennessee Regional office did not maintain back-up documentation for health and welfare monitoring. Survey results were documented and final reports disseminated, and these are the records that were maintained. However, without all documentation of the monitoring activities, TennCare cannot be certain

contract requirements regarding assurances of health and welfare and of financial accountability were met.

Recommendation

The Director of TennCare should ensure DMR complies with contractual requirements for assurances of health and welfare and of financial accountability. TennCare should also provide DMR with adequate monitoring policies and procedures to ensure all federal requirements are met.

Management's Comment

We concur. TennCare will work with DMRS to ensure compliance with the interagency agreement and will provide adequate monitoring policies and procedures to ensure all federal requirements are met.

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11. Claims for services provided to the mentally retarded and developmentally disabled have not been paid in accordance with the Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Waiver

Finding

TennCare has allowed other state departments to contract with and to pay Medicaid providers in violation of the terms of the Medicaid Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Waiver (HCBS waiver). The *Code of Federal Regulations* Title 45, Part 431, Section 10(e)(3), allows other state and local agencies or offices to perform services for the single state Medicaid agency. As a result, TennCare has contracted with the Division of Mental Retardation Services (DMR) in the Department of Finance and Administration to oversee the HCBS waiver program. In addition, DMR relies on the Department of Mental Health and Mental Retardation to perform certain fiscal responsibilities under the waiver.

Although the state Medicaid agency can use other state departments to perform services, Sections 1905(a) and 1902(a)(32) of the Social Security Act and the HCBS waiver require the Tennessee Department of Health (including TennCare), the single state Medicaid agency, to make direct payments to providers of services covered by the waiver. In addition, the waiver agreement requires provider claims to be processed on an approved TennCare/Medicaid Management Information System (TCMIS) and provider payments to be issued by the fiscal agent for TennCare, Electronic Data Systems (EDS). However, TennCare has allowed DMR to process claims on its own system and make payments through the State of Tennessee Accounting and Reporting System (STARS) directly to providers.

Section 1902(a)(27) of the Social Security Act and the HCBS waiver also require TennCare to contract directly with the providers. However, TennCare has allowed DMR to contract with the Medicaid providers directly. Furthermore, TennCare has inappropriately paid DMR as a Medicaid provider. DMR in turn has treated the actual Medicaid providers of services as DMR vendors. According to Medicaid principles, as described in the Provider Reimbursement Manual, Part I, Section 2402.1, DMR is not a Medicaid provider because it does not perform actual Medicaid services.

DMR has paid waiver claims outside the prescribed waiver arrangement. The waiver is designed to afford eligible individuals access to home and community based services as authorized by Section 1915(c) of the Social Security Act. Typically, any claims submitted by providers for services performed to waiver recipients would be processed in accordance with all applicable federal regulations and waiver requirements. In addition, the state would receive the federal match funded at the appropriate federal financial participation rate. However, DMR and TennCare have not processed waiver claims within federal requirements. As a result, the state contributed state funds for the waiver services, without maximizing federal financial participation. For example, DMR has paid providers for services that cannot be charged to the federal grantor because they are not allowable under the waiver regulations.

Per Office of Management and Budget (OMB) Circular A-133, for costs to be allowable Medicaid costs, claims must be for allowable services rendered that are supported by records or other evidence indicating the services were provided and consistent with a recipient's plan of care for HCBS waiver services. In addition, the *Code of Federal Regulations* Title 42, Part 1003, Section 102, states that penalties or assessments may be imposed by the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) if an item or service was not provided as claimed. Furthermore, the Federal Register (FR) August 10, 1995, Volume 60, Pages 40847-40851: Notices *OIG Special Fraud Alerts* states that claiming unperformed or excessive services is fraud and may be prosecuted by the OIG.

The HCBS waiver requirements prohibit services for recipients when they are absent from their homes. In addition, the HCBS waiver does not permit recipient leave days because care is home based and not performed in a residential facility. TennCare forwarded DMR a transmittal letter from the Health Care Financing Administration (HCFA) of HHS dated October 31, 1994, stating that leave days could not be paid for by the HCBS waiver. However, DMR implemented a system that would, in essence, permit patient leave days. For example, providers performing services for 300 days are paid the same amount as providers performing services for 365 days. DMR has also paid the providers rates that exceed the TennCare rates. In addition, the DMR payment system has no controls to prevent payment for unperformed services and TennCare has no controls to detect if DMR were to bill for unallowable leave days and unperformed services.

The current billing and payment process is as follows:

1. Medicaid services providers perform services for waiver recipients.
2. Providers bill DMR for services.

3. DMR pays providers based on rates established by DMR, but not the rates calculated in the waiver by TennCare. TennCare's rates are based on average cost per service. DMR's uses the Community Services Tracking System and the State of Tennessee Accounting and Reporting System to pay the providers.
4. DMR bills TennCare, as if DMR was a provider, based on the TennCare rates.
5. TennCare pays DMR, as if DMR was a provider, the TennCare rates using the TCMIS system.
6. Per the agreement with TennCare and DMR, at year-end TennCare and DMR intended to cost settle so that DMR could receive the difference between its full payment for services paid to providers and the amount which has been reimbursed by TennCare based on the TennCare rates.

Although TennCare management intended to cost settle with DMR, as described above, discussions with management subsequent to field work revealed that management will seek guidance from the grantor prior to proceeding with any cost settlement.

Because TennCare has not ensured DMR complied with the waiver and federal regulations, DMR has paid Medicaid providers more than the TennCare rates, and in some cases has paid for unallowable leave days and unperformed services. DMR requires providers to bill using a standardized form generated by DMR that allows the providers to bill for total authorized services rather than for services that are actually performed. Because DMR does not provide a mechanism that allows providers to report/bill actual services performed, DMR has paid providers for all authorized services when actual services performed were less than those authorized. Testwork revealed that in one of 33 claims tested, a provider billed for more staff than was actually present for 21 of 28 days in the July 1998 billing period. Testwork also revealed that DMR used a payment and rate methodology that allowed providers to be paid for days (leave days) in which waiver recipients were not receiving services. In 8 of 33 claims tested, DMR paid Medicaid service providers for a full month service when less than a full month of service was actually performed.

Because TennCare and DMR have administered the waiver outside the federal regulations, if an exception is not granted by HCFA, the state will have forgone $30,631,388 of federal financial participation.

Recommendation

The Director of TennCare should take immediate action to comply with all federal requirements, including those in the waiver, so as to maximize all federal financial participation. The Director must also inform DMR of all federal requirements, including those in the waiver, and ensure that DMR complies with all requirements. The Director should ensure that TennCare pays providers in accordance with the waiver and only for allowable services that are actually performed. TennCare should process claims on an approved Medicaid (TennCare) Management Information System and pay providers directly. DMR provider billings to TennCare should reflect only the actual level of services performed. The Director of TennCare should ensure staff performs fiscal monitoring of providers to ensure payments are for services actually provided.

Management's Comment

We concur. We will work with HCFA to ensure that our waiver procedures are in compliance with all federal requirements for the waiver and will work with DMRS to ensure their compliance with all waiver requirements. Any procedures necessary to ensure maximum federal participation will be pursued. Provisions will be implemented that allow the provider voluntary reassignment of their service payment to a government agency, i.e., DMRS, with the ability to cancel the arrangement should he choose to receive direct payment from the Medicaid agency. As a long-term goal, we will work toward the federal requirement that the Medicaid agency make payments directly to the provider of services. This effort will not be completed for several years due to computer system limitations.

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12. The TennCare Bureau should amend its cost allocation plan

Finding

The state has a Medicaid cost allocation plan to provide for the recovery of administrative costs. However, the plan has not been amended to cover the administrative costs associated with the Home and Community Based Services (HCBS) for the Mentally Retarded and Developmentally Disabled Waiver program. Currently the Department of Finance and Administration's Division of Mental Retardation Services (DMR) has the responsibility for day-to-day management of the HCBS waiver program. The audit revealed that the Bureau of TennCare has paid the Division of Mental Retardation Services administrative costs based on 7 percent of HCBS paid claims without an approved amended cost allocation plan. For the year ended June 30, 1999, this amount totaled $6,193,035, consisting of $4,097,126 in federal questioned costs and $2,095,909 in state matching funds. This practice has been occurring since fiscal year 1997.

Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments, Attachment D, Public Assistance Cost Allocation Plans*, requires an approved cost allocation plan for all direct and indirect administrative costs for public assistance programs. Without an appropriately amended and approved plan, the TennCare Bureau is not eligible to recover these costs from the federal grantor.

Recommendation

The TennCare Director should immediately develop and submit an amended cost allocation plan in accordance with OMB Circular A-87.

Management's Comment

We concur. The Bureau is currently in the process of developing a cost allocation plan to be submitted for approval as determined necessary.

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13. TennCare has not ensured an adequate process is in place for approval and review of services for the Medicaid Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Waiver

Finding

TennCare has not ensured the Division of Mental Retardation Services (DMR) appropriately reviews and authorizes allowable services for recipients of the Medicaid Home and Community Based Services for the Mentally Retarded and Developmentally Disabled Waiver (HCBS waiver). In addition, DMR does not adequately document the review and approval of services on the Individual Service Plan (ISP).

Section 13 of the HCBS waiver states services under the waiver will be furnished pursuant to an approved plan of care. Documentation of approval of plan of care services is performed on the ISP based on appendix E of the HCBS waiver document. DMR's *Operation Manual for Community Providers*, chapter two, requires ISPs to be authorized before entry into DMR's Community Service Tracking System as approved. In addition, Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, states costs must be documented.

Auditors tested a sample of claims totaling $42,311. Testwork revealed that for 31 of 33 claims tested (93.9%), the ISPs were not signed and dated by anyone authorizing and approving services under the HCBS waiver. Discussion with auditee personnel concerning these ISPs revealed that they were not reviewed. The auditor could not determine the services were properly authorized. Federal questioned costs totaled $27,328. An additional $13,980 of state matching funds was related to the federal questioned costs. The total claims paid by TennCare for the year ended June 30, 1999, was $82,278,890.

Without approved plans of care, Medicaid providers of HCBS waiver services may be paid for unallowable services.

Recommendation

The Director of TennCare should ensure that DMR adequately documents approval of services under the HCBS waiver and reviews approvals for allowability. The approval and

review should be appropriately documented on the ISP. The Director should ensure TennCare monitors this process for compliance.

Management's Comment

We concur. Although the ISP (Individual Service Plan) was not signed as stated in the finding, there was a signed individual cost plan that is prepared as a direct result of the ISP. The current service authorization process will be reviewed by TennCare staff and if determined appropriate, an amendment to the HCBS Waiver will be submitted to HCFA to clarify the process that will be used to provide documentation of services authorized and approved for waiver participants. During the required annual state assessment, the TennCare monitor will review for the proper signatures.

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14. TennCare should develop adequate controls to prevent capitation payments on behalf of enrollees who become incarcerated and amend its policies to permit full recovery of related overpayments

Finding

TennCare does not have adequate controls in place to prevent capitation payments to managed care organizations and behavioral health organizations when enrollees become incarcerated. In addition, TennCare does not have a process to retroactively recover all capitation payments from the MCOs when enrollees are incarcerated.

The capitation payments are made to the MCOs and BHOs on behalf of TennCare enrollees to cover medical and mental health services. These payments are generated electronically each month by the TennCare Management Information System (TCMIS) based upon the recipient eligibility information contained in the system. If the eligibility information in TCMIS is not updated timely, then erroneous payments will be made.

TennCare personnel stated that data received from the Tennessee Department of Correction is often incomplete and/or inaccurate. Prisoners are often not willing to give complete and/or accurate information regarding their identity (name, social security number, date of birth, etc.). These problems can often cause delays in identification of prisoners and stopping of benefits.

Using computer-assisted audit techniques, a search of TennCare's paid claims tapes revealed that TennCare made capitation payments totaling $1,125,283.81 from July 1, 1998, to June 30, 1999, for over 600 adult inmates in state prisons. Of this amount, $946,278.56 was paid to MCOs, of which $597,645.88 is federal questioned costs. An additional $348,632.68 of state matching funds was related to the federal questioned costs.

BHOs are not to be reimbursed for costs associated with incarcerated adults. The total payments to the two BHOs are based on a predetermined budget for mental health services approved by HCFA. These payments are allocated between the BHOs based on the number of eligible clients. Eligibility includes not being incarcerated. When a BHO has included ineligible clients in its population of TennCare eligible clients, the portion of the money budgeted for that BHO should be reduced to that extent and awarded to the other BHO. The total amount paid to the BHOs is not affected. Thus, the total amount paid to the BHOs is not a questioned cost in this audit.

Although the total amount paid to the BHOs is not affected, future funding might be affected. When ineligible individuals are included in the population, then the population is skewed and could affect assumptions made when determining the amount of the global budget paid to the BHOs in the future.

Under federal regulations (*Code of Federal Regulations*, Title 42, Part 435, Sections 1008 and 1009), the state, not the federal government, is responsible for the health care costs of adult inmates.

Based on discussions with TennCare's Director of Information Services, management's current policies do not always prevent capitation payments from being made when enrollees are incarcerated. Current policy also prevents TennCare from fully recovering from the MCOs all capitation payments made since the date of incarceration. The policies include

- Management's policy decision not to disenroll any SSI (Supplemental Security Income) enrollees, until notification of death or proof the individual has elected Medicaid coverage in another state.

- Management's policy decision to use date of notification of incarceration rather than exact date of incarceration. For example, if a person was incarcerated in June 1998 and TennCare was notified in September 1998, TennCare would only recover capitation payments made beginning September 1998, rather than going back to the exact date of incarceration in June.

In addition to TennCare's policy, it is also possible that current MCO contract language might prevent total recovery of all capitation payments made to them in error. Current contract language allows TennCare to recover payments retroactively in cases of an enrollee's death or if there has been fraudulent enrollment committed by the enrollee.

Recommendation

Under the leadership of the Director of TennCare, management should determine which capitation payments, made on behalf of incarcerated adults, can legally be recovered and take the necessary steps to recover all such payments. The Director of TennCare should ensure that the Director of Information Services continues to monitor its methodology to detect incarcerated

adults and to prevent future payments for adult inmates. Management should also consider whether any action is necessary regarding the monthly allocation of funds between the BHOs.

TennCare should consider changes in the MCO contract language to clearly allow full recovery of capitation payments for ineligible enrollees. Otherwise, TennCare should develop a mechanism to identify these payments and use only state dollars to pay for incarcerated enrollees.

Management's Comment

We concur. TennCare will continue to review and monitor its procedures for identifying incarcerated adults and determine which capitation payments can legally be recovered. If capitation payments can not be recovered to the time of incarceration, the State will determine if State dollars should be used to fund the unrecovered dollars.

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15. Deceased enrollee payment recovery procedures need improvement

Finding

As noted in the prior audit, procedures for deceased enrollee payment recovery need improvement. Although management concurred with the prior finding and improvements have been made, testwork revealed the following weakness.

According to TennCare staff, often there can be delays in obtaining information about deceased individuals. Thus it is important to retroactively recover payments when there is a delay in the death notification. However, the TCMIS is currently set up to recover payments retroactively to only 12 months before the date of death notification. When it takes over a year to detect an enrollee's death, TennCare does not recover all of the previous capitation payments made for deceased individuals.

A manager in the Division of Information Services stated that TCMIS is capable of recovering beyond the 12 months but that management has not authorized recovery beyond 12 months. In addition, a manager in the Contract Compliance Division stated that TennCare could contractually recover all payments made to the MCOs since the date of death of the enrollee. Furthermore, MCO contract language indicates that TennCare can retroactively recover payments for deceased individuals without limitation.

Recommendation

Under the direction of the Director of TennCare, TennCare management should take the necessary steps to recover all capitation payments made on behalf of deceased recipients since

the inception of TennCare. Management should recover all capitation payments for deceased enrollees back to the date of death.

Management's Comment

We concur. Retroactive recovery of capitation payments beyond 12 months of the date of death notification to TennCare has not occurred. Procedures will be established to allow recoveries for capitation payments that exceed the twelve-month reconciliation for identified deceased enrollees.

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16. TennCare continues to disregard its own rules regarding overpayments to providers and needs to improve processing of Medicare cross-over claims

Finding

As noted in the three prior audits, TennCare has not complied with departmental rules resulting in overpayments to providers caring for enrollees who are both TennCare and Medicare recipients. Management concurred with the prior finding and stated that TennCare staff will work to bring payment methods into compliance with departmental rules. According to the Director of Fiscal Services as of November 1999, TennCare is still researching the rules and has not determined whether or not it is more appropriate to change the rules or the computer system. As noted in the prior two audits, TennCare has not improved control weaknesses in processing the Medicare cross-over claims. Management concurred with the prior findings and stated it would examine its process for updating policies, procedures, and computer systems for changes necessary to reflect new developments. However, no changes to the computer system have been made.

Medicare recipients are required to pay coinsurance and a deductible to the provider for services received. If the patient is also eligible for Medicaid, Medicare bills TennCare instead of the patient for the coinsurance and deductible. According to the *Rules of the Tennessee Department of Health*, Chapter 1200-13-1.05, the total amount paid by all parties (Medicare, patient, and TennCare) cannot exceed the fee limitations set by TennCare. This rule seems appropriate. Therefore, it appears the systems rather than the rule should be changed. However, TennCare's computer system always pays the entire deductible billed for outpatient hospitalization services regardless of how much Medicare or the patient paid or any limitations set by the Medicaid fee schedule.

In addition, there were several control weaknesses in the processing of Medicare professional and institutional cross-over claims (claims paid partially by both Medicare and Medicaid). The TennCare Management Information System (TCMIS) used to process these claims has not been modified and updated as needed to ensure claims are paid in compliance with state and federal laws. As noted above, the *Rules of the Tennessee Department of Health,*

Chapter 1200-13-1.05, require that the total amount paid by all parties not exceed the fee limitations. However, TCMIS does not always ensure that claims from psychologists and social workers comply with this rule. The amount of expenditures for professional and institutional cross-over claims during the year ended June 30, 1999, was approximately $72 million.

The following control weaknesses were noted:

- Although professional cross-over claims from psychologists and social workers have been Medicaid-eligible since the late 1980s, these claims are to be denied if the recipients have other insurance (third-party resources). However, TCMIS has not been updated to detect third-party resources on these cross-over claims. It is very likely that TennCare has paid claims that should have been denied because other insurance was available.

- Despite the complex nature of the claims processing, Bureau staff does not routinely perform manual pricing tests to determine if the system is paying claims properly.

- TennCare's policies and procedures regarding fee-for-service claims are not adequate.

- Auditor inquiry revealed that the TennCare Bureau did not have sufficient knowledge of the rules and regulations pertaining to TennCare's financial obligation and responsibility for Medicare cross-over claims to develop effective policies and procedures. In addition, no staff at the TennCare Bureau was assigned responsibility to monitor changes in laws and regulations regarding Medicare cross-over claims.

Recommendation

The Director of TennCare should decide what action is necessary to ensure compliance and then make the necessary changes to the TennCare Management Information System to bring the method of payment into compliance with departmental rules. The Director of TennCare should ensure TCMIS has been updated to detect third-party resources on cross-over claims and should ensure that TennCare's policies and procedures regarding fee-for-services claims are adequate. Management and staff should keep abreast of new and changing program requirements and should ensure the Bureau's policies, procedures, and computer systems are updated timely to reflect new developments. Also, the Director of TennCare should ensure the claims pricing and payment subsystem of TCMIS is routinely tested.

Management's Comment

We concur. TennCare is continuing to review payment procedures that are not in accordance with departmental rules. As determined appropriate, the rules or the procedures will be modified accordingly. Procedures will be implemented to ensure the claims pricing and payment subsystem is routinely tested.

17. Controls over access to the TennCare Management Information System need improvement

Finding

As noted in the prior audit, one of the most important responsibilities, if not the most important, for the official in charge of an information system is security. The Director of TennCare is responsible for, but did not ensure that, adequate TennCare Management Information System (TCMIS) access controls were in place throughout the audit period. As a result, deficiencies in controls were noted during system security testwork.

The TCMIS contains extensive recipient, provider, and payment data files; processes a high volume of transactions; and generates numerous types of reports. Who has access, and the type of access permitted, is critical to the integrity and performance of the TennCare program. Good security controls provide that access to data and transaction screens be limited to a "need-to-know, need-to-do" basis. When system access is not properly controlled, there is a greater risk that individuals may make unauthorized changes to the TCMIS or inappropriately obtain confidential information, such as recipient social security and Medicaid identification numbers, income, and medical information. Audit testwork revealed the following discrepancies.

No Standardized Security Authorization Forms

Access to TCMIS is controlled by Resource Access Control Facility (RACF) software. The purpose of RACF is to prohibit unauthorized access to confidential information and system transactions. The TennCare Security Administrator in the Division of Information Services is responsible for implementing RACF, as well as other, system security procedures.

The Security Administrator assigns a "username" ("RACF User ID") and establishes at least one "user group" for all TennCare Bureau and TCMIS contractor users. User groups are a primary method by which RACF controls access. Each member of a user group can access a set of TCMIS transaction screens.

Throughout the audit period, the security administrator did not require users to fill out security access forms documenting the level of access requested. Failure to require signed security authorization forms with proper supervisory approval makes it more difficult to monitor user access. For example, it is not possible to compare the type and level of access needed and requested with the type and level of access given. On July 12, 1999, TennCare started requiring standardized justification forms to be filled out by all new users to TennCare's system. For a portion of the year, TennCare required users to justify their reasons for access to TennCare's system; however, this form did not document the level of access requested.

Unnecessary Access to TCMIS

User access testwork revealed that all users in the default group had the ability to update at least two screens. This could be accomplished by typing over the "function" field and

replacing INQ (inquiry) with CHG (change). Then the user could make changes to the screens and press a particular function key to update. Management sent a work request to the contractor, EDS, on August 11, 1999, to explore the problem. As of October 25, 1999, the EDS had not completed the work.

Transaction Screens Not Protected

As discussed earlier in this finding, typically users must have a RACF user ID to sign on to TCMIS and access TennCare transaction screens. The auditors discovered that two transaction screens, "long-term care history inquiry" and "TennCare master application," could be accessed without a user ID. This could occur if a user pressed a particular function key during the sign-on process. The function key enabled the user to bypass the sign-on process and go directly to the transaction command screen. At that point, the user could enter one of the transaction screen commands and obtain unauthorized access.

This condition apparently existed because security levels for many screens were set to minimal values to facilitate a quick switchover when the old Medicaid system was modified for TennCare purposes in 1994. Management corrected other screens noted in the last audit where this problem occurred. However, management failed to adequately review the screens and ensure that all screens were protected.

Security Administration Not Centralized

Testwork also revealed that the Security Administrator for the Department of Health, who is separate from TennCare's Security Administrator, has the ability to give users access to TCMIS. Management stated that the Department of Health's Security Administrator is required to notify the TennCare Security Administrator when users are given access to TCMIS. However, an examination of usage logs revealed that there were at least two occasions where the Department of Health administrator acted before consulting TennCare.

Furthermore, if users' RACF user names expire, the TennCare Security Administrator can reinstate the access of users given by the department's Security Administrator, and vice versa. When access to TCMIS is decentralized, it is more difficult to monitor and control.

Recommendation

The Director of TennCare should ensure that the standardized authorization forms are obtained for all users that have access to TCMIS. In addition, the director should ensure that these forms are collected from all existing users. The director should ensure that all transaction screens are properly secured from unauthorized access. Access levels for all screens should be reviewed to guarantee that only authorized users have the ability to make changes. Responsibility for TCMIS security should be centralized under the TennCare Security Administrator.

Management's Comment

We concur. Security Authorization Forms were initially implemented in November of 1993. All users were required to sign the agreement forms, which were maintained by Information Services. As referenced in the finding on July 12, 1999, the security authorization form was revised to include a section for manager written approval and a section for designated level of access.

Information Services is currently in system testing with the Facilities Manager Contractor to correct function deficiency which allows inappropriate access.

Effective immediately, only the TennCare Security Administrator can now authorize access to the TCMIS.

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18. Controls over the administration and monitoring of contracts should be improved

Finding

The Department of Health, Bureau of TennCare, needs to strengthen controls over the administration and monitoring of contracts. In accordance with the TennCare Waiver, the Department of Commerce and Insurance, TennCare Examiners Division, is responsible for conducting examinations of Managed Care Organizations (MCOs) and Behavioral Health Organizations (BHOs) that contract with the Bureau of TennCare. Commerce and Insurance conducts these examinations of MCOs and BHOs to ensure financial viability and compliance with statutory and contractual provisions, and rules and regulations. The scope of services provided by Commerce and Insurance includes financial review, complaint negotiation, claims process monitoring, and assessments of financial position. Although Commerce and Insurance is performing these services, which are completely funded by the TennCare program, testwork revealed that the Bureau of TennCare has not initiated an interdepartmental contract with the Department of Commerce and Insurance.

The Department of Health also has a cooperative agreement with the Department of Human Services for the determination of Medicaid eligibility. This agreement has not been revised or amended since October 1969, when the original agreement started. The TennCare program was implemented in January 1994 after the state obtained a waiver from the federal Health Care Financing Administration, which allowed the state to replace its basic Medicaid program (Medical Assistance Program) with a managed care system. Since the agreement has not been revised or amended since 1969, the TennCare program is not included in the agreement. Furthermore, the cooperative agreement does not provide sufficient detail to ensure all parties are fully informed of the scope of services and related responsibilities. The agreement states that the Department of Public Welfare [currently known as the Department of Human Services (DHS)] assumed responsibility of "the determination of eligibility" for Medicaid recipients. However,

the agreement does not provide detail of which policies, standards, or methods should be used to make the eligibility determinations.

Testwork also revealed that the Bureau's controls over the monitoring of contracts is inadequate. The Bureau has not implemented written policies and procedures to monitor all of the Bureau's contracts. In addition to the Commerce and Insurance arrangement, the Bureau contracts with other entities, including state departments, to assist with the TennCare program. As noted in other findings, the Bureau does not have effective monitoring procedures to ensure contract compliance. Examples of these contracts include the following:

- a contract with the Department of Commerce and Insurance to conduct examinations of the MCOs and BHOs to ensure financial viability and compliance with statutory and contractual obligations;

- a contract with the Comptroller of the Treasury, Medicaid/TennCare Division, to establish reimbursable cost rates for the Tennessee Medicaid Title XIX and the TennCare Waiver Programs;

- a contract with First Mental Health Incorporated to provide external reviews to monitor quality assurance;

- a contract with the Department of Children's Services to provide non-medical treatment and case management services;

- a contract with the Department of Human Services to provide Medicaid eligibility determinations; and

- a contract with the Department of Health's Office of Health Licensure and Regulation to certify healthcare facilities.

Without effective monitoring procedures, the Bureau cannot ensure that compliance requirements of the contract are met.

Recommendation

The Department of Health, Bureau of TennCare, should establish an interdepartmental contract with the Department of Commerce and Insurance to formally document the existing agreement between the two departments. The Director of TennCare should revise the cooperative agreement to ensure all parties are fully informed of the scope of services and specific responsibilities. In addition, the agreement should be revised to reflect the TennCare program and the rules that govern the program. The Director of TennCare should also develop and implement written policies and procedures to monitor contracts.

Management's Comment

We concur. TennCare will work with Commerce and Insurance in establishing a formal interdepartmental contract for the examinations of the MCOs and BHOs. TennCare will also update other interagency agreements between state agencies to reflect the needs of the current program. TennCare will continue to review those contracts that have not been monitored and will determine the most appropriate monitoring efforts. The Department of Health submitted its Contract Monitoring Plan for FY 1999-2000 contracts by September 30, 1999 as required by Policy # 22. At that time, TennCare was still part of the Department of Health. Through this process contracts were identified as low, medium or high risk for monitoring prioritization purposes. Consistent with the results of this assessment, monitoring schedules were developed to allow fiscal and program monitoring of all contractors to be accomplished on a three year schedule at a minimum.

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19. TennCare committed funds without approval

Finding

Since July 1, 1999, the Department of Health, Bureau of TennCare, committed state and federal TennCare funds before it had a contract with the Department of Children's Services to provide services. This contract serves as the legal instrument governing the activities of TennCare as they relate to the Department of Children's Services and specifies the scope of services, grant terms, payment terms, and other conditions. As of December 10, 1999, an interdepartmental grant agreement between the Department of Finance and Administration, Bureau of TennCare, and the Department of Children's Services had not been executed for the period July 1, 1999, through June 30, 2000. Executive order No. 23 transferred the TennCare program from the Department of Health to the Department of Finance and Administration effective October 19, 1999.

Recommendation

The Department of Finance and Administration, Bureau of TennCare, and the Depart–ment of Children's Services should ensure that a contract between the two departments is in place at the start of each fiscal year before services are provided.

Management's Comment

We concur. We are working with DCS to get a signed contract and will make every attempt to have contracts signed and recorded prior to services being delivered.

20. TennCare has not monitored the graduate medical schools

Finding

As noted in the previous audit, TennCare has not monitored the graduate medical schools to ensure requirements related to graduate medical education (GME) payments are met, nor has TennCare advised the graduate medical schools of the audit requirements of subrecipients. Management concurred with the previous year's audit finding and stated that the Bureau would advise the subrecipients of the audit requirements for subrecipients of federal funds. Management also stated that the medical schools were included in the contract-monitoring plan submitted to the Department of Finance and Administration in accordance with Policy 22. However, the Bureau did not advise the subrecipients of the audit requirements. The Bureau also did not do what it said it would do in the monitoring plan.

GME payments are made to the state's four graduate medical schools: (1) the University of Tennessee at Memphis, (2) Vanderbilt University, (3) Meharry Medical College, and (4) East Tennessee State University. The GME payments consist of three components: a hospital pass-through component, a primary care allocation component, and a resident stipend component. The hospital pass-through funds are paid to the medical schools, which are required to allocate the funds to the hospitals designated in the GME plan. Under the primary care allocation, the GME dollars are supposed to follow the residents to their sites of training. The amount of each school's primary care component is awarded to a resident in family practice, internal medicine, pediatrics, or obstetrics during the year of residency for which the resident agrees to participate and to serve TennCare enrollees in a "Health Resource Shortage Area" of Tennessee. During the year ended June 30, 1999, GME expenditures were approximately $48 million.

TennCare does not monitor the graduate medical schools to ensure the following:

- The hospital pass-through component dollars paid to the hospitals designated in the GME plan are properly allocated.
- The lists of residents used to determine the primary care component are valid.
- The graduate medical schools have taken appropriate action to correct federal compliance audit findings.

TennCare relies on the graduate medical schools to comply with the terms of their agreement and does not monitor the graduate medical schools to ensure requirements are met.

Office of Management and Budget (OMB) Circular A-133 also requires the department to monitor subrecipients' activities to provide reasonable assurance that the subrecipients administer federal awards in compliance with federal requirements. OMB Circular A-133 also

requires the department to ensure that required audits are performed and that subrecipients take prompt corrective action on any audit findings.

Finance and Administration (F&A) policy 22 also requires the departments to monitor subrecipients. Policy 22 establishes a guideline for the monitoring of subrecipients of state agencies. The policy requires the departments to submit monitoring plans each fiscal year beginning after June 30, 1998. TennCare submitted a monitoring plan but did not do what it said it would do in the plan.

The department cannot determine subrecipients' compliance with applicable regulations if appropriate monitoring procedures are not performed and required audits are not obtained. Furthermore, funds could be used for objectives not associated with the grant, and subrecipient errors and irregularities could occur and not be detected.

Recommendation

TennCare should immediately advise the graduate medical schools of the audit requirements for subrecipients of federal funds. The Director of TennCare should establish a monitoring program to monitor the graduate medical schools to ensure compliance with grant requirements. All monitoring should be sufficiently documented and deficiencies should be promptly reported to the graduate medical schools. TennCare should also require the schools to submit corrective action plans.

Management's Comment

We concur. The monitoring of the graduate medical schools is included in the Departments Policy 22 monitoring plan. The FY99 GME contracts will be included in the interdepartmental agreement with F&A to perform the contract monitoring during FY2000. TennCare will advise the graduate medical schools of the audit requirements for sub-recipients of federal funds.

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21. Because of uncollected cost settlements, TennCare has remitted $10.2 million in state dollars to the federal government

Finding

As noted in the past three audits covering July 1, 1995, through June 30, 1998, because TennCare has failed to collect Medicaid cost settlements from providers, state dollars have been used to pay the federal portion of the cost settlements. (A cost settlement due the state can occur if the annual review of a provider's cost report discloses that the cost of services or charges for services were less than the payments the provider received.) The federal grantor, the Health

Care Financing Administration (HCFA), requires the state to remit the federal share (approximately two-thirds) within 60 days of settlement, whether or not the state has collected the amounts due from the providers.

TennCare pursues collection of the cost settlement receivables before and, if necessary, after the federal share of the cost settlement receivables has been remitted to HCFA. Management concurred with the prior findings and stated that staff has aggressively pursued reducing the outstanding cost settlement balances. However, compared to the amount reported in the prior year, little improvement has been made. At June 30, 1999, the cost settlements over 60 days old were $15,290,190.78. Approximately two-thirds ($10.2 million) of this amount has been returned to the grantor, using state funds. This is a decrease in the amount of $2,508,526.82 from the amount reported in November of 1998 ($17,798,717.60.)

According to TennCare's records, two hospitals had the largest overdue cost settlement balances at June 30, 1999: Regional Medical Center at Memphis ($3,845,322.93) and George W. Hubbard Hospital of Meharry College in Nashville ($2,916,485.00). Management is uncertain whether the Regional Medical Center at Memphis has the resources to pay its cost settlements and indicated that the hospital has questioned various aspects of its settlements. As a result, TennCare has taken no action to collect from the hospital or write off the uncollectible account. TennCare management has taken action to resolve the Hubbard account by writing off the outstanding amount for Hubbard. This request for a write-off was completed in December 1999.

Because of the difficulty with collecting cost settlements directly from providers, TennCare, in cooperation with the Medicare program administered by the federal government, initiated garnishment of providers' Medicare payments. (Only one payment of $4,143.00 was collected through Medicare garnishment in the year ended June 30, 1999.) However, TennCare refrained from asking Medicare to garnish all of the outstanding cost settlement receivables because of accounting differences between the two financial information systems that contained provider balances—the TennCare Management Information System (TCMIS) and the Medicaid Accounts Receivable Recoupment System.

Although management delayed the requests to Medicare and the financial information from the Recoupment System was questionable, TennCare management used this information to remit amounts and report quarterly to HCFA.

Management stated that it was also exploring having the Department of Finance and Administration use STARS to withhold other departments' and agencies' payments to providers. Section 9-4-604, *Tennessee Code Annotated*, provides authority for this procedure:

> No person shall draw any money from the public treasury until all debts, dues, and demands owing by such person to the state are first liquidated and paid off. The commissioner of finance and administration shall not issue any warrants upon the treasury in favor of a person in default until all of such person's arrearages to the treasury are audited and paid.

In the prior audit, TennCare had requested that the Department of Finance and Administration withhold payments to only one provider, collecting $6,409.39. For the year ending June 30, 1999, an additional $35,909.70 was withheld.

TennCare management believes that many of the cost settlements are uncollectible; however, for the year ended June 30, 1999, only one outstanding cost settlement receivable totaling $3,718 was written off.

It is in the state's best interest to resolve the cost settlement accounts receivable as quickly as possible through collection or write-off after all other efforts have been exhausted. Using state funds to remit the providers' share to HCFA deprives the state of the use of these funds. If the state determines that some of the accounts are uncollectible and the accounts are written off, the state may, in certain cases (such as bankruptcy), recover what has already been remitted to HCFA.

Recommendation

The Director of TennCare and the Fiscal Director should continue efforts to collect all outstanding cost settlements or write off all uncollectible accounts promptly. When accounts are written off due to bankruptcy of the provider, management should take the necessary steps to obtain a refund from the grantor for the amounts remitted using state funds.

Management should take immediate measures to resolve any questions concerning the amounts owed and each provider's ability to pay. If necessary, assistance from the Office of the Attorney General should be obtained. The Fiscal Director should continue to contact the Department of Finance and Administration about withholding additional payments through STARS.

Management's Comment

We concur. The Department continues to review avenues to collect any portion of these dollars that can be collected or written off, if determined appropriate. The write-off request for the Meharry balance due has been approved and is no longer included in our outstanding balance. We are sending demand letters to all current accounts as they are received. Additional efforts are also being taken on those accounts that are over 90 days old, with continued efforts to collect unpaid amounts through STARS and/or Medicare.

22. TennCare needs to improve policies and procedures for accounts receivable

Finding

As noted in the prior audit, TennCare has not established adequate overall policies and procedures for accounts receivable. Management concurred and stated it would begin the process of developing policies and procedures for monitoring, collecting, and recording in the State of Tennessee Accounting and Reporting System (STARS), and writing off TennCare's accounts receivable.

Testwork revealed that TennCare's management is still in the process of developing written policies and procedures for recording all accounts receivable in STARS and for monitoring, collecting, and writing off accounts receivable. TennCare's receivables consist mainly of cost settlements, drug rebates, and enrollee premiums. Management considers many of these receivables to be uncollectible. The total uncollectible amount for the three categories is approximately $31 million. Since TennCare does not have policies and procedures for attempting to collect or writing off the uncollectible balances, the uncollectible balances continue to increase. See finding 21 for more information on cost settlements.

Testwork also revealed several discrepancies in the controls over enrollee premiums receivable. Premiums are collected from enrollees who are classified as uninsured and uninsurable. These enrollees are required to pay premiums in order to receive health services under the program. TennCare is responsible for maintaining the enrollee's premium account and for determining the applicable monthly premium amount based on an enrollee's income and family size.

Testwork revealed that TennCare was not properly verifying and reverifying eligibility for the purpose of cost sharing (premiums) (see finding 3 for more information). Therefore, proper premiums may not be charged to enrollees.

In addition, TennCare did not comply with the *Rules of the Department of Finance and Administration*, Division of Accounts, Chapter 0620-1-9, for writing off accounts receivable. According to this policy and procedure, "any write-off of any account of one thousand dollars or greater or accounts aggregating five thousand dollars ($5,000) or more must have the prior written approval of the Commissioner of Finance and Administration and the Comptroller of the Treasury." For the year ended June 30, 1999, in response to a court case, TennCare wrote off approximately $34.8 million of outstanding premiums without proper approval. In addition, management could not provide written approvals by their own agency officials as is required by the policy.

Furthermore, testwork revealed inadequate controls to ensure the accuracy of premium reporting. The TennCare Bureau prepares a cumulative premium report each month to track the total premiums billed to enrollees, the total amount remitted by enrollees, the total amount due

from enrollees, and the total premium statements mailed to enrollees for each month. Management uses this report to develop premium estimates for financial reporting purposes. Our review of this cumulative report revealed several inconsistencies that jeopardize the reliability of this report. The report provided to the auditors during this audit period contained differences from the report used in the prior audit. For example, the amount of premiums billed for the month of January 1994 was different on the two reports. Although the amount should not have changed, the report auditors received in 1999 showed January 1994 billings as $485,645.03 and the 1998 report showed January 1994 billings as $487,046.29. In addition, the column that summarizes total due from enrollees reported balances when in fact these receivable balances had been written off by management. Management could not provide any explanation for the inconsistencies but stated that the discrepancies resulted from computer programming errors. As a result, auditors could not rely on the reports as evidence of TennCare's controls over premium reporting or for developing premium estimates.

The Division of Budget and Finance prepares deposit slips and records the deposits in STARS for the enrollee premiums collected. However, responsibility for the premium billing and collection process has been assigned to the Division of Information Services. It may be more appropriate if the Division of Budget and Finance is given responsibility for billing, and collecting enrollee premiums. This would place the billing and collection duties in a more logical location and allow the Division of Information Services to focus on Information Services functions.

Recommendation

The Director of TennCare should ensure that policies and procedures for overall accounts receivable functions are completed and implemented. Furthermore, the Director of TennCare should strengthen controls over premiums for the uninsured and uninsurable enrollees. Controls should include accurate premium reporting and proper write-off of uncollectible premium receivables. In addition, the TennCare Director should consider assigning responsibility for controls over premiums entirely to the Division of Budget and Finance.

Management's Comment

We concur. Policies and procedures are being developed to include monitoring, collecting writing off and recording in STARS the TennCare accounts receivable, which includes premium collections. TennCare staff will work with other state agencies to document the establishment of accounts receivable at year end. TennCare will review the current controls and procedures relative to premium collections and determine if the responsibility should be in the Division of Budget and Finance.

23. Policies and procedures for accrued liabilities need improvement

Finding

As noted in the prior audit, TennCare's policies and procedures for accrued liabilities were not adequate. Due to these inadequacies, numerous deficiencies in TennCare's accrued liabilities records were noted. Management concurred with the prior finding and stated it would begin the process of developing policies and procedures. As of December 1999, management stated that these policies and procedures were still being developed. However, management could not provide a draft of the policies and procedures.

As part of the state's year-end financial closing procedures, management determines, and then records in the State of Tennessee Accounting and Reporting System (STARS) the accrued liabilities for the TennCare program. For the year ended June 30, 1999, the total amount of TennCare's accrued liabilities recorded in STARS was $380,296,563.24. However, after testwork was completed, it appeared that management had overstated the accrued liabilities by $94,505,924.98. Testwork revealed the following:

- Management recorded a $50 million liability for a special payment to hospitals and a $30 million liability to Xantus at June 30, 1999. However, neither of these items were a liability of TennCare at June 30, 1999. Management made an adjustment for $80,000,000 to the general fund.

- Management obtained and recorded estimated accrued liability amounts from the Department of Children's Services, the Department of Mental Health and Mental Retardation (DMHMR), and the Medicaid/TennCare Section of the Comptroller's Office. However, management did not obtain and review sufficient supporting documentation for the amounts recorded, nor did it get assurance from these departments that the liability balances were accurate. For example, TennCare's Fiscal Director could not provide support for the TennCare-related accrued liabilities for DMHMR; therefore, the auditor had to obtain the information from the Fiscal Director at DMHMR. As a result of the audit testwork, many discrepancies were noted and adjustments to the accrued liabilities for DMHMR were proposed.

- Medicaid provider cost settlement receivables and payables were improperly netted by category in STARS. For example, all hospital receivables were netted with all hospital payables, instead of by individual hospital. In addition, all total net amounts, by category, also were netted together. For example, all hospital receivables/payables were netted with all nursing home receivables/payables.

Proper accounting policies and procedures ensure that the financial information used for decision-making and state and federal reporting is accurate.

Recommendation

The Director of TennCare should ensure the Fiscal Director obtains accurate and sufficiently detailed supporting documentation for amounts which will be recorded in STARS. In addition, the Fiscal Director should ensure liabilities accrued by his office are carefully prepared and reviewed.

The Fiscal Director also should ensure that receivables and payables (liabilities) are accounted for separately and consistently. Amounts should be netted on an individual provider or account basis only, if deemed necessary.

Management's Comment

We concur. Policies and procedures are being developed to ensure accrued liabilities are adequately documented before recording in STARS. TennCare staff will work with other state agencies to document the establishment of accrued liabilities at yearend and will net accounts receivables and accrued liabilities only when deemed necessary.

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24. Controls over checks should be strengthened

Finding

The TennCare Bureau needs to improve controls over manual and system checks. For the year ended June 30, 1999, these checks totaled over $3.6 billion.

Electronic Data Systems (EDS), the fiscal agent, is responsible for preparing the checks. However, EDS has not established adequate controls over checks. In addition, existing controls are not adequately documented in the fiscal agent's policies and procedures. The following deficiencies were noted:

- Manual and system check stock is kept in a locked room. Procedures require two EDS employees to be present when retrieving the check stock. For the manual checks, this is to be documented by both employees signing the manual check log before obtaining the key to the room to retrieve check stock. For 3 of 53 times (5.7%) that manual checks were drawn, the manual check log was only signed by one individual. Prior to May 1999, the fiscal agent did not maintain a system check log to ensure all system checks were accounted for properly. In addition, EDS does not record receipt of blank system checks for accountability.

- Physical security over the manual and system check stock is compromised because the room key and the key logs are not kept together. Thus, the keys could be obtained without anyone signing the log.

- The rubber stamp used to sign manual checks, signature plates used to sign system checks, and completed checks are kept in a locked box located in a locked room along with partially completed checks. Before obtaining any one or more of these items, two individuals from EDS should sign the key log. For 153 of 595 times (25.7%) the key was used, the log was signed by only one individual.

- Although EDS began system check logs in May 1999, systems check logs were not reconciled to the TennCare Management Information System (TCMIS) to ensure all checks were accounted for properly.

- EDS does not reconcile between the manual check log to checks that are completed to ensure all checks were accounted for.

These weaknesses in the controls over checks could permit an individual to gain access to checks without detection. In addition, these weaknesses in controls could permit an individual to control the whole check process and issue a check for unauthorized purposes.

The only compensating control used was a reconciliation of checks issued and cleared each month. This reconciliation involves records from the Department of the Treasury (Treasury), the Department of Finance and Administration's Division of Accounts, and TennCare. This reconciliation ensures that TennCare's and Treasury's records of checks issued and cleared correspond to State of Tennessee Accounting and Reporting System (STARS). However, this control is not entirely effective because reconciliations were not always completed in a timely manner. For example, the December 1998, January 1999, February 1999, March 1999, and April 1999 Treasury ARP reconciliations were not given to TennCare until June 1999.

Effective internal controls require that no one person have the ability to control the entire check-issuance process and that reconciliations of accounting records to bank activity are timely.

Recommendation

The Director of TennCare should ensure the fiscal agent has adequate controls over access to manual and system checks. In addition, each month the Department of the Treasury, the Division of Accounts, and TennCare should promptly reconcile checks issued and cleared with Account Reconciliation Package (ARP), STARS, and TCMIS records. Check logs should be reconciled to checks issued to ensure accountability. In addition, manual check logs should always be used to record the receipt and issuance of manual checks.

Management's Comment

We concur. The reconciliation process between STARS, TCMIS and Treasury is now current. We continue to monitor the Fiscal Agent to insure adequate segregation of duties and have taken action to notify EDS management of the weakness.

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25. The Bureau's overall compliance with the special terms and conditions of the TennCare program need improvement

Finding

The TennCare Bureau has not complied with all of the TennCare waiver's Special Terms and Conditions (STCs). There are 37 special terms and conditions for the TennCare Waiver; however, only 24 were applicable for the audit period. These special terms and conditions required by the Health Care Financing Administration describe in detail the nature, character, and extent of anticipated federal involvement in the TennCare waiver. HCFA's approval of the waiver and federal matching contributions are contingent upon the Bureau's compliance with the Special Terms and Conditions.

A review of the Bureau's controls and procedures to ensure compliance with the Special Terms and Conditions revealed that many areas need improvement. Compliance audit procedures performed revealed instances of noncompliance for nine of the 24 applicable special terms and conditions. The nine STCs that require improvement were:

- STC 1 – All contracts and modifications of existing contracts between the state and managed care organizations must be approved by HCFA prior to the effective date of the contract or modification of an existing contract. No federal financial participation will be available for any contract or modification of an existing contract not approved by HCFA in advance of its effective date. In order to comply with this STC, the Bureau must submit a final contract or modification of an existing contract 30 days prior to the effective date of the contract. The Bureau did not provide proposed contract amendments to HCFA in a timely manner to allow HCFA the full 30 days for review.

- STC 3 – The state will conduct beneficiary surveys each operational year of the demonstration. The state shall conduct a statistically valid sample of all TennCare enrollees. Results of the survey and an electronic file containing the raw data collected must be provided to HCFA by the ninth month of each operational year. The Bureau did not include all TennCare enrollees in its sample methodology. Nursing home residents, homeless people, and the disabled population were not included in the sample methodology. Survey results and an electronic file containing

the raw data collected was not provided to HCFA by the ninth month of the operational years ended September 30, 1998, and September 30, 1999.

- STC 4 – The state must perform periodic reviews, including validation studies, in order to ensure compliance. The state shall have provisions in its contracts with health plans to provide the data and be authorized to impose financial penalties if accurate data are not submitted in a timely fashion. The STC requires validation studies to ensure accuracy. Validation of encounter data should include medical record reviews. The MCOs and BHOs did not provide encounter data in a timely manner. The Bureau did not have a written methodology and timeframe for conducting validation studies to include medical record reviews during the audit period.

- STC 5 – The state's plan for using encounter data to pursue health care quality improvement must focus on the following priority areas: childhood immunizations, prenatal care, pediatric asthma, and two clinical conditions based upon the population served. It appears that the Bureau has not established an exact deadline for the MCOs to submit the encounter data for the studies. The continuation of these studies is required by the STC. The Bureau did not provide written documentation to HCFA on the status of current studies, a schedule of planned studies, or a timeframe for completion of the studies, to ensure compliance with the ongoing requirements of the STC.

- STC 9 – The state must develop internal and external audit plans to monitor the performance of the program. The Bureau did not have a written comprehensive plan for monitoring the TennCare program. The Bureau does have some monitoring procedures in place; however an overall plan to study the activities of the project had not been drafted as of the audit period.

- STC 19 – The state must submit quarterly progress reports to HCFA. Guidelines for these reports were provided to the Bureau in October 1995. The Bureau of TennCare did not follow report guidelines established by the grantor and did not report significant information in the HCFA quarterly progress reports.

- STC 23 – The state must continue to ensure that an adequate MIS is in place. The TCMIS needs improvement. See finding 2.

- STC 24 – The state must continue to assure that its eligibility determinations are accurate. The Bureau's internal control over eligibility determinations is inadequate. See finding 3.

- STC 37 – Alternative monitoring approaches will be required until the state can demonstrate that it can use valid encounter data for monitoring the demonstration. The Bureau has not provided a work plan for alternative monitoring approaches.

Without adequate controls to ensure overall compliance with the Special Terms and Conditions, TennCare may lose federal participation in the program.

Recommendation

The Director of TennCare should ensure compliance with all special terms and conditions. The Director should consider assigning responsibility to a specific individual within the Bureau to monitor compliance with the STCs.

Management's Comment

We concur. We are working with HCFA to ensure compliance with the Special Terms and Conditions.

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26. Internal control over provider eligibility and enrollment was not adequate to ensure compliance with Medicaid provider regulations

Finding

The TennCare program did not have adequate internal control for provider eligibility and enrollment to ensure compliance with Medicaid provider regulations. As noted in the prior audit, TennCare did not reverify licensure for Medicare cross-over providers or monitor the enrollment of Medicaid providers by the Department of Children's Services (Children's Services). Management concurred with the finding and stated that, "An aggressive approach for verification and reverification is a key element of the Bureau's strategic plan." However, no procedures were developed to reverify licensure.

In addition, management stated they had arranged for the Department of Finance and Administration (F&A) to assist in monitoring provider enrollment at Children's Services. However, F&A did not monitor Children's Services' provider eligibility and enrollment procedures. According to the Director of Financial Systems Consulting Group at F&A, the monitoring staff performed fiscal monitoring procedures at Children's Services during the last four months of the fiscal year. At that time, F&A verified that a sample of providers had a current license; however, this verification was not documented.

TennCare also had the following other internal control weakness and noncompliance issues:

- TennCare had no provider eligibility and enrollment policies and procedures manual;

- the licensure status of managed care organization (MCO) and behavioral health organization (BHO) providers was not reverified after the providers were enrolled;

- TennCare's contracts with Children's Services and the Division of Mental Retardation Services (DMR) in the Department of Finance and Administration did not require these departments to comply with Medicaid provider rules and regulations, and as a result, Children's Services and DMR did not comply;

- TennCare did not monitor the enrollment of Medicaid providers at DMR;

- DMR did not reverify the licensure of individual providers;

- provider agreements did not comply with all applicable federal requirements;

- not all providers had a provider agreement, as required; and

- a DMR provider was not licensed for over 10 months.

Compliance with applicable rules and regulations, as well as a system of internal control to ensure that compliance, is necessary to ensure that the providers participating in the TennCare program are qualified and that they meet all eligibility requirements.

Responsibility for TennCare provider eligibility and enrollment is divided among the Provider Enrollment Unit in the Division of Operations, Bureau of TennCare; the Division of Resource Management in Children's Services; and the East, Middle, and West Tennessee regional offices in DMR. The Provider Enrollment Unit is responsible for enrolling MCO and BHO providers; Medicare cross-over individual and group providers (providers whose claims are partially paid by both Medicare and Medicaid/TennCare); and long-term care facilities.

Children's Services is responsible for the eligibility of the providers it pays to provide Medicaid-covered services to eligible children. DMR is responsible for the eligibility of the providers it pays to provide services under the Home and Community Based Services Waiver for the Mentally Retarded (HCBS-MR waiver) program. (DMR is responsible for the daily operations of this Medicaid program. See finding 8.) TennCare reimburses Children's Services and DMR for payments to these providers.

No Policies and Procedures Manual

The TennCare Provider Enrollment Unit does not have a policies and procedures manual. The Provider Enrollment Unit supervisor stated that she had been working on a draft copy since January 1999. The lack of written, comprehensive provider eligibility and enrollment policies and procedures increases the risk that errors or inconsistencies may occur in this area.

Provider Licensure Not Reverified

The Provider Enrollment Unit and DMR enroll providers licensed by the Division of Health Related Boards in the Department of Health. Although the Division of Health Related Boards does not notify the Provider Enrollment Unit and DMR when a provider's license is

suspended or terminated, the Division of Health Related Boards has two systems, one on the Internet and an automated telephone system, so that the current status of a provider's license can be verified. During the year ended June 30, 1999, neither the Provider Enrollment Unit nor DMR used either system to reverify licensure.

The Provider Enrollment Unit, DMR, and Children's Services also enroll providers licensed or certified by the Board for Licensing Health Care Facilities (Health Care Facilities) in the Department of Health. Health Care Facilities notified the Provider Enrollment Unit when a provider's certification was suspended or terminated; however, Health Care Facilities did not notify Children's Services or DMR when a provider's license was suspended or terminated. Although these departments were not notified, Children's Services took the initiative to reverify licensure, but DMR did not.

The departmental *Rules for the Bureau of TennCare*, section 1200-13-12-.08, "Providers," states that participation in the TennCare/Medicaid program is limited to providers that "maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice, or licensure by the Tennessee Department of Mental Health and Mental Retardation."

Children's Services and DMR Did Not Always Comply With Medicaid Provider Rules and Regulations.

The contracts between TennCare and Children's Services and DMR do not state, as they should, that these departments are required to follow Medicaid federal and state provider rules and regulations. In addition, TennCare did not monitor the enrollment of Medicaid providers at Children's Services and DMR. As a result, Children's Services and DMR did not always comply with Medicaid provider rules and regulations. For example, Children's Services and DMR did not comply with *Code of Federal Regulations* (CFR), Title 42, Part 431, Section 107, "Required Provider Agreement." (This regulation is discussed further in the next section of this finding.)

Provider Agreements Not Adequate

Except for its agreements with long-term care facilities, TennCare's provider agreements did not comply with federal requirements. The Tennessee Medicaid state plan says, "With respect to agreements between the Medicaid agency and each provider furnishing services under the plan the requirements of 42 CFR 431.107 are met." This regulation states,

> A State plan must provide for an agreement between the Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to: (1) Keep any records necessary to disclose the extent of services the provider furnishes to recipients; (2) On request, furnish to the Medicaid agency, the Secretary, or the State Medicaid fraud control unit any information maintained under (1) and any information regarding payments claimed by the provider for furnishing services under the plan; (3) Comply with the disclosure requirements specified in part 455, subpart B.

The agreement for individual cross-over, MCO, and BHO providers did not meet the criteria in (1), (2), and (3). The agreement for group cross-over providers did not meet the criteria in (1) and (2). However, it met the criteria in (3): 42 CFR 455, subpart B, "Disclosure of Information by Providers and Fiscal Agents," which requires providers to disclose ownership and control information and information on a provider's owners and other persons convicted of criminal offenses against Medicare or Medicaid.

The Medicare program, which is administered by the federal government, enrolls cross-over providers before the Provider Enrollment Unit enrolls them in Medicaid/TennCare. According to the manager of the Provider Enrollment Unit, Medicare providers must also meet the requirements of 42 CFR 431.107, and Medicaid/TennCare has relied on Medicare's enrollment procedures since the beginning of the Medicaid program. Auditors requested that management provide documentation from the grantor that would indicate it was permissible for TennCare to rely on Medicare in this area; however, no documentation was provided. In addition, the auditors did not find any references in the CFR or Tennessee Medicaid State Plan that indicated that reliance on Medicare is permitted.

Not All Providers Had an Agreement

The auditors tested a sample of payments to long-term care facility providers to determine if TennCare had a provider agreement on file for the dates of services for which each payment was made. TennCare issues a new provider agreement to long-term care providers after the Board for Licensing Health Care Facilities recertifies them annually. As mentioned above, the State Plan and CFR Title 42, Part 431, Section 107, require that providers have a provider agreement. TennCare paid a total of $951,724,634.88 to long-term care facilities for the year ended June 30, 1999.

Auditors tested 245 payments totaling $695,683. Testwork revealed that for 6 of 245 tested (3%) totaling $21,106, there was no provider agreement on file for the dates of service tested. Federal questioned costs totaled $13,330. An additional $7,776 of state matching funds was related to the federal question costs.

Unlicensed DMR Provider

During testwork, the auditors noted that an HCBS-MR waiver program provider was not licensed from February 1, 1998, through November 11, 1998. In March 1998, the Middle Tennessee Licensure Office in the Department of Mental Health and Mental Retardation notified DMR that the provider no longer was licensed after licensure inspectors discovered that the provider had moved to a new location earlier in the year. This was discovered when the inspectors attempted to perform the provider's annual relicensing inspection. According to licensure regulations, a facility loses its license upon relocation, and the provider did not meet all licensure requirements at its new location until November.

However, according to TennCare's records, during the year ended June 30, 1999, it reimbursed DMR $2,565,019 for services this provider performed between May 1, 1998, and November 11, 1998. As a result, $1,620,002 of federal costs will be questioned. An additional $945,017 of state matching funds is related to these questioned costs.

Recommendation

The Director of TennCare should ensure that adequate internal control exists for determining and maintaining provider eligibility. Management and staff should comply with all Medicaid federal and state provider rules and regulations. The Medicaid/TennCare provider eligibility and enrollment policies and procedures manual should be finalized and distributed to all parties involved in this function. The Director should ensure that procedures are implemented to reverify licensure and to prevent future payments to non-licensed providers.

All Medicaid/TennCare providers should have a provider agreement and otherwise be properly enrolled before they are allowed to participate in the program. The provider agreements should be revised to comply with the State Plan and the *Code of Federal Regulations*. Management should also consider obtaining permission from the grantor to change the State Plan to allow reliance on Medicare for cross-over provider agreements.

In addition, Children's Services and DMR should comply with all Medicaid federal and state provider rules and regulations. The Director should ensure that these departments are informed of their responsibilities for compliance, and the Director of the Division of Finance and Budget should add these requirements to the contracts with these departments. The Director should ensure that knowledgeable staff monitors the enrollment of Medicaid providers at Children's Services and DMR.

Management's Comment

We concur in part. The Bureau has taken the position and continues to take the position that our reliance on Medicare's licensure verification for crossover providers is sufficient. However, we do randomly reverify the licensure of providers. Staffing limitations prohibit the reverification of licensure of all providers. While there may be some potential for a provider's license to be revoked or suspended during the period after which Medicare has verified the provider's license and the provider is enrolled in as a cross over provider, we are not aware of an instance in which this has occurred. HCFA has also reviewed our provider agreements in the past and has not found them to be problematic. For certain types of providers, the provider application serves as an "agreement".

The MCOs and BHOs have extensive credentialling procedures, which include verification of licensure. When the Bureau "enrolls" an MCO or BHO provider who does not bill for crossover payments, the provider's number is not activated.

With respect to DCS, the agency itself is the Medicaid provider, rather than its individual contractors. DCS contracts with residential providers for a comprehensive array of services to children in its custody. These services include room and board, social services, educational services, and other kinds of services other than medical care. These agencies are licensed and monitored by DCS, and they are paid a single daily rate that includes the treatment and the non-treatment portions of their services. The treatment portion is calculated according to a cost

allocation plan approved by HCFA and is billed to TennCare by DCS. Treatment services must be delivered according to requirements outlined in the Medicaid/Title V agreement.

We will work to develop, finalize and distribute a written provider eligibility and enrollment policies and procedures manual.

Rebuttal

In the previous audit report, management stated,

> We concur. We will examine the procedures for enrollment verification and develop remedies for the deficiencies noted. An aggressive approach for verification and reverification is a key element of the Bureau's strategic plan. We have arranged for the Department of Finance and Administration to assist us in monitoring several aspects of the Department of Children's Services and will include provider enrollment in that review.

In addition, management has stated that, currently, provider eligibility is not a priority. While it is necessary and reasonable that management set priorities for the program, these priorities do not affect the auditor's responsibility to examine controls and determine compliance with laws, regulations, contracts, and agreements, and to report instances of noncompliance, questioned costs, and weaknesses in internal control.

As noted in the finding, TennCare is responsible for ensuring that the providers that participate in the Medicaid/TennCare program (i.e., the providers that are paid for providing services to Medicaid/TennCare recipients) are properly licensed or certified, as required. The U.S. Office of Management and Budget A-133 *Compliance Supplement* specifically requires the auditors to review and test controls and compliance in the area of "Provider Eligibility" (see section/page 4-93.778-16).

During the audit, the auditor discussed with management, at length, the TennCare provider enrollment unit's policies and procedures. We agree that reliance on Medicare may be acceptable for initial enrollment of cross-over providers. However, it would appear that controls could be strengthened and information received more quickly if TennCare's provider enrollment unit received notice of suspended licenses of providers from the Department of Health's Division of Health Related Boards. This way, rather than having to systematically reverify the licensure status of every provider, the provider enrollment unit could rely on updates received.

With regard to provider agreements, during audit fieldwork the auditor was not informed that the Health Care Financing Administration (HCFA) had reviewed the provider agreements and had "not found them to be problematic." During fieldwork the auditors compared the provider agreements currently in use to the requirements stated in Title 42 of the *Code of Federal Regulations* (CFR) and, as noted in the finding, several instances of noncompliance were noted. It is the auditor's understanding that any form of provider agreement (application, contract, etc.) should meet all of the requirements stated in the federal regulations.

On numerous occasions during fieldwork, the auditors asked management for any documentation that would exempt providers of Medicaid services enrolled by the Department of Children's Services (Children's Services) and the Division of Mental Retardation Services (DMR) in the Department of Finance and Administration from being considered Medicaid providers. No such documentation was provided. We believe the entities providing the direct services for treatment are Medicaid providers and should be enrolled as providers under Medicaid regulations. Since Medicaid/TennCare funds are used to reimburse Children's Services and DMR for Medicaid-covered services provided to Medicaid-eligible recipients, Children's Services and DMR providers should be subject to the Medicaid provider requirements? like the providers enrolled by TennCare's provider enrollment unit. Also, because of the decentralized nature of provider enrollment, it is important for TennCare to adequately monitor Medicaid provider eligibility and enrollment procedures at Children's Services and DMR.

In regard to the MCO and BHO providers, according to the supervisor of the provider enrollment unit, providers that wish to provide TennCare services through an MCO or BHO must first be determined eligible and enrolled by the TennCare provider enrollment unit. The provider enrollment unit follows its standard eligibility and enrollment procedures for these providers. After a provider has been determined eligible and has been enrolled at TennCare, the provider then may enter into an agreement with an MCO or BHO.

In addition to these matters, management did not address the following items discussed in the finding:

- not all providers had a provider agreement, as required, which resulted in federal questioned costs;
- an unlicensed provider was paid over $2.5 million, resulting in questioned costs of over $1.6 million; and
- the auditor's various concerns pertaining to Medicaid providers used by DMR for the Medicaid Home and Community Based Services Waiver Program for the Mentally Retarded and Developmentally Disabled.

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27. TennCare did not comply with federal regulations and the Tennessee Medicaid State Plan concerning unnecessary utilization of care and services and suspected fraud

Finding

The Bureau of TennCare has not complied with federal regulations and the Tennessee Medicaid State Plan concerning unnecessary utilization of care and services and for suspected fraud for areas of the program that are still under the fee-for-service arrangement. In 1994, the

state received a waiver from the Health Care Financing Administration to implement a managed care demonstration project. However, the services provided in the long-term care facilities, services provided to children in the state's custody, and services provided under the Medicaid Home and Community Based Waiver for the Mentally Retarded and Developmentally Disabled are still processed on a fee-for-service basis. Discussions with key TennCare management and the supervisor of the Program Integrity Unit in the Department of Health revealed that

- TennCare has no "methods or procedures to safeguard against unnecessary utilization of care and services," except for long-term care institutions;

- for all types of services, including long-term care, there are no procedures for the "ongoing post-payment review . . . of the need for and the quality and timeliness of Medicaid services"; and

- there are no methods or procedures to identify suspected fraud related to "children's therapeutic intervention" claims and claims for the Home and Community Based Services waiver for the mentally retarded.

According to the Office of Management and Budget "A-133 Compliance Supplement," which references the *Code of Federal Regulations,* Title 42, parts 455, 456, and 1002,

> The State Plan must provide methods and procedures to safeguard against unnecessary utilization of care and services, including long-term care institutions. In addition, the State must have: (1) methods or criteria for identifying suspected fraud cases; (2) methods for investigating these cases; and, (3) procedures, developed in cooperation with legal authorities, for referring suspected fraud cases to law enforcement officials. . . .
>
> The State Medicaid agency must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. The agency must have procedures for the ongoing post-payment review, on a sample basis, of the need for and the quality and timeliness of Medicaid services.

In addition, the TennCare Bureau has told the federal grantor in the Tennessee Medicaid State Plan that

> A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services.

However, audit testwork revealed there is no statewide program of surveillance and utilization control.

Management stated that the program-wide surveillance and utilization control program was eliminated when the state began the managed care program under the TennCare waiver.

Auditors requested that management provide documentation from the grantor that would indicate that the federal regulations concerning utilization control and fraud were not applicable to the fee-for-service based areas of the TennCare program. However, no documentation was provided. Although much of the TennCare program operates differently than the former Medicaid fee-for-service program, auditors believe that, for areas that still operate under the Medicaid fee-for-service program, program-wide surveillance and utilization control and identification of suspected fraud, effort is needed to help ensure that state and federal funds are used only for valid medical assistance payments.

It should be noted that the Medicaid Fraud Control Unit (MFCU) in the Tennessee Bureau of Investigation is responsible for investigating suspected cases of provider fraud referred to them by TennCare or other sources. The MFCU is not responsible for performing utilization control procedures or trying to locate and identify fraud in the TennCare/Medicaid program. In a letter to the Director of State Audit dated April 5, 1999, the Special Agent-in-Charge of the MFCU wrote that, prior to TennCare, the MFCU had relied on the former Surveillance and Utilization Review System Unit "to refer suspected activities to the MFCU for follow up."

In addition to the matters discussed in this finding, a March 1999 Performance Audit report by this office contains the finding "MCOs *(managed care organizations)* and BHOs *(behavioral health organizations)* have not made sufficient effort to detect fraud and abuse."

Recommendation

The Director of TennCare should either take the appropriate steps to ensure compliance with the federal regulations and State Plan provisions concerning utilization control and identification of fraud for the areas of the program that are still fee-for-service based or obtain documentation from the grantor that compliance is not required and amend the State Plan.

Management's Comment

We concur. TennCare will review current procedures for compliance with federal regulations and the Tennessee Medicaid State Plan relative to unnecessary utilization of care and services and suspected fraud. As determined necessary, amendments to the Tennessee Medicaid State Plan will be submitted to HCFA for approval to address changes in procedures that have occurred to the Medicaid/TennCare Program.

28. TennCare did not comply with audit requirements for long-term care facilities

Finding

The Bureau of TennCare has not ensured that audits of long-term care facilities are performed as required by the Tennessee Medicaid State Plan and the departmental Rules for Medicaid. According to the State Plan, "Each cost report [of the long-term care facilities] submitted in accordance with the Plan shall be audited by a Certified Public Accountant or a licensed Public Accountant, engaged by the provider, and shall include the auditor's report." The departmental *Rules for Medicaid* (Rule 1200-13-6-09, item 32) state, "It is the responsibility of the management of the facility to engage an independent certified public accountant or public accountant to audit the facility. . . . The audit must be completed in accordance with the agreed upon procedures explained in the auditor's report which is a part of the cost report." The Bureau of TennCare has not required these audits for several years but has not amended the State Plan or the Rules for Medicaid.

Audits of long-term care facilities are required by the *Code of Federal Regulations,* Title 42, Part 447, Section 253(g), which states, "The Medicaid Agency must provide for periodic audits of the financial and statistical records of participating providers." The April 1999 Office of Management and Budget *Compliance Supplement* references this citation and states, "The specific audit requirements will be established by the State Plan. . . . Such audits could include desk audits of cost reports in addition to field audits. These audits are an important control for the State Medicaid agency in ensuring that established payment rates are proper."

According to the State Plan,

> on-site audits of the financial and statistical records will be performed each year in at least 15% of the participating facilities. At least 5% of these shall be selected on a random sample basis and the remainder shall be selected on the basis of the desk review or other exception criteria. The audit program shall meet generally accepted auditing standards. This program shall provide procedures to certify the accuracy of the financial and statistical data on the cost report and to insure that only those expense items that this Plan has specified as allowable costs have been included by the provider.

The Bureau of TennCare contracts with the Medicaid/TennCare Section of the Comptroller's Office for the provision of these auditing services and establishment of reimbursable cost rate(s) for the Tennessee Medicaid Title XIX and TennCare Waiver Programs. The Medicaid/TennCare Section of the Comptroller's Office performs desk reviews of all long-term care facility cost reports. However, 15% of the long-term care facilities do not receive field audits as indicated in the State Plan. Only one audit report, for the field audit of one intermediate care facility for the mentally retarded (ICF/MR), was released in the year ended June 30, 1999.

There are 323 long-term care facilities (including intermediate care facilities for the mentally retarded) in Tennessee that receive Medicaid funds. During the year ended June 30, 1999, TennCare paid approximately $950 million to these facilities for long-term care services. The cost reports are used to set the rates that the facilities are paid. If the cost information is not verified through the required audit process, errors, fraud, illegal acts, and other noncompliance may not be detected. Potentially a facility could record inaccurate information on its cost report in order to receive a higher rate. The result of inaccurate cost reports of the intermediate care facilities for the mentally retarded could be added cost for the TennCare program. Other types of long-term care facilities could benefit from incorrect cost reports, but at the expense of the other facilities rather than the TennCare program.

Recommendation

The Director of TennCare should take the appropriate steps to ensure compliance with the provisions of the State Plan and the Rules for Medicaid concerning audits of long-term care facilities. Otherwise, the Director should obtain permission from the grantor to amend the State Plan and change the applicable Medicaid Rule through the state's rule-making process.

Management's Comments

Bureau of TennCare

We concur. TennCare will submit a state plan amendment to delete the requirement for independent CPA audits of nursing home cost reports and require audits as determined reasonable and necessary. The Comptroller will continue to perform desk reviews and field audits as determined reasonable and necessary.

Medicaid/TennCare Section

We are not in compliance with the current state plan provision requiring 15% annual audit coverage of Medicaid long-term care providers. We would request that the TennCare Bureau apply for a change in the plan to delete the 15% requirement which is no longer federally mandated, and replace it with language that refers to a level of auditing necessary to assure reasonable compliance with program rules.

Since the TennCare waiver began in 1994, we have focused audit resources on the managed care organizations (MCOs) and relied mostly on an aggressive desk review process to verify the accuracy of cost reports submitted by long-term care providers. The MCOs do not file cost reports, and represent a greater risk of noncompliance with program requirements. Regardless of the 15% provision in the present state plan, we recognize the need to increase the number of long-term provider audits that are conducted and are now working in that direction.

About three years ago, we requested that the department promulgate a rule change deleting the independent CPA audits of nursing home cost reports. Our desk review process was

showing that those audits were not accomplishing their intended purpose. There was a projected savings to the program of about $1.5 million for this change. The rule making hearing was held and there were no objections to the rule change. For some reason, however, the rule was never completed. The rule is now being moved through the remaining steps necessary to make it final. We would request that the TennCare Bureau, in addition to completing that rule, also apply for an amendment to remove the provision from the state plan.

Our commitment at this time is to add at least 3 more staff to long-term care audits and allocate some current resources back to this area without affecting the level of work needed on TennCare MCOs. By 2001, field audits of long-term care providers should be restored to a level that will comply with an amended state plan to assure that reimbursement rates are proper.

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29. TennCare has not established a coordinated program for ADP risk analysis and system security review

Finding

As noted in the prior two audits, TennCare does not have a coordinated program for ADP (automated data processing) risk analysis and system security review of the TennCare Management Information System (TCMIS). Management concurred with the prior-year findings and stated that the bureau was seeking guidance from the Health Care Financing Administration (HCFA) regarding its expectations for this regulation and would take steps to comply with HCFA's guidance. Currently, the Bureau has received no guidance from HCFA. The Bureau has relied on the Department of Finance and Administration's Office for Information Resources (OIR) for security of TCMIS, and the system operations are being analyzed and reviewed for the Year 2000 project; however, the Bureau has been unable to comply with federal regulations which require establishing a program for ADP risk analysis and system security review.

According to Office of Management and Budget (OMB) Circular A-133 and the *Code of Federal Regulations*, Title 45, Subtitle A, Section 95.621, such an analysis and a review must be performed on all projects under development and on all state operating systems involved in the administration of the Department of Health and Human Services' programs. TCMIS is such an operating system and is one of the largest in the state.

The risk analysis is to ensure that appropriate, cost-effective safeguards are incorporated into the new or existing system and is to be performed "whenever significant system changes occur." The system security review is to be performed biennially and include, at a minimum, "an evaluation of physical and data security operating procedures, and personnel practices." This review is to be followed by a "written summary of the State's findings and determination of compliance with these ADP security requirements." These reports are to be produced by TennCare along with supporting documentation to be available for federal onsite reviews.

If TennCare is to rely on TCMIS for the proper payment of benefits, a security plan, which includes risk analysis and system security review, must be performed for this extensive and complex computer system. OMB Circular A-133 requires the plan to include policies and procedures to address the following:

- Physical security of ADP resources
- Equipment security to protect equipment from theft and unauthorized use
- Software and data security
- Telecommunications security
- Personnel security
- Contingency plans to meet critical processing needs in the event of short- or long-term interruption of service
- Emergency preparedness
- Designation of an agency ADP security manager

Recommendation

The Commissioner and the Assistant Commissioner for TennCare should ensure that the Director of Information Services promptly develops and implements procedures for ADP risk analysis and system security review. The Assistant Commissioner should look to staff to take the initiative in analyzing and reviewing these important areas with or without guidance from HCFA. Once procedures are in place, the Assistant Commissioner for TennCare should monitor the procedures implemented and ensure that the appropriate actions have been taken.

Management's Comment

We concur. TennCare has confirmed with HCFA Regional Office Staff Analyst that the procedures described as follows are a coordinated program for ADP analysis. In addition HCFA and their Y2K Independent Validation and Verification team assessed the TCMIS to be at low risk on TCMIS system and Business Continuity and Contingency Plan (BCCP) readiness. A timetable will be developed for future reviews and procedures will be implemented to monitor the process and ensure that the appropriate actions have been taken.

During the Year 2000 Project, the Bureau of TennCare focused on managing risks by identifying them, evaluating their consequences and preventing them from happening. Ultimately, our risk management approach was by problem identification followed by problem solving. Each agency within the TennCare Bureau conducted its own risk management and

impact analysis study by assessing their daily operations and critical business functions. Information derived from each unit within the TCMIS was then used to assess the operation and determine mission critical areas that were potentially vulnerable to operational failure. The critical process, systems and equipment within each area were evaluated in support of each critical function. The detailed risk analysis focused on areas having the greatest negative impact on the Bureau's critical services and functions. Resultant was the projected restoration of normal operations if operational problems were encountered, giving likelihood of success along with the degree of risk. The detailed information has been included in the TennCare Business Continuity and Contingency Plan.

During the risk analysis and the development of the TennCare BCCP, all personnel were trained in the implementation and utilization of the plan. The plan was also tested to adequately allow for the continuation of business operations in both short and long term.

At the enterprise level, TennCare operations include the utilization of a group of 8 managed care organizations (MCO's) and 2 behavioral health organizations (BHO's) whose functions are monitored by the state. Each of the MCO's and BHO's associated with the TennCare system have submitted their BCCP to TennCare.

TennCare realizes that the BCCP is not a static document and will require maintenance as conditions dictate. The Director of Information Services will appoint a person whose responsibility will be to update and redistribute the BCCP as changes become necessary. BCCP changes include, but are not limited to, software changes, staffing changes, management changes and hardware changes.

Auditor's Comment

Although management concurred, we do not believe their proposed actions are adequate. Furthermore, we do not believe the actions described by management qualify as a coordinated program for ADP risk analysis and system security review. The proposed actions do not include establishing and maintaining a program for conducting periodic risk analyses to ensure that appropriate, cost effective safeguards are incorporated into new and existing systems as required by OMB Circular A-133.

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30. TennCare approved a pre-admission evaluation that did not contain the signature of a physician

Finding

TennCare inappropriately approved a pre-admission evaluation (PAE) and allowed an individual to receive services without a physician's order. TennCare's registered nursing staff approves or denies PAEs of persons applying for Medicaid reimbursements for covered services

at long-term health care facilities. The PAEs are either approved or denied based on the *Rules of the Tennessee Department of Health*, Chapter 1200-13-1.10, which state that "all care rendered must be pursuant to the order of a physician. . . ."

During the year ending June 30, 1999, TennCare paid approximately $950 million to long-term health care facilities. Testwork revealed that for a sample of 60 PAEs totaling $156,753.01, one did not contain a physician's signature, which is required to certify that the requested level of care is medically necessary, and that the patient's medical needs can be met in a long-term health care facility. The PAE without adequate documentation should have been denied and returned to the facility with a notice of denial; however, it was approved incorrectly and services were provided. The cost of the claim was $3,985.10. Federal questioned costs totaled $2,516.89. An additional $1,468.21 of state matching funds was related to the federal questioned costs. We believe likely questioned costs associated with this condition could exceed $10,000.

Recommendation

The Director of Long-Term Care should ensure the assessments of the PAEs are accurate and in compliance with established rules.

Management's Comment

We concur. TennCare will continually emphasize to the nurses who do the PAE review of the requirement that all PAE's have the appropriate signatures before approval is granted.

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31. TennCare did not follow its own rules and has not revised its rules

Finding

As noted in the prior three audits, the Bureau of TennCare has not followed several of the departmental rules it created. Among the reasons cited for bypassing the rules were that some rules were out-of-date and no longer addressed the situation and that adherence to some of the rules was not feasible. Management concurred with the prior three findings and stated that during 1997 the Bureau and the Office of General Counsel began an extensive review to identify rules that needed to be revised to reflect current policy. However, certain rules have not been through the complete rule making process.

Tennessee Code Annotated prescribes the method for adopting departmental rules. Except for emergency or public-necessity rules, an agency must publish its proposed rule in the Secretary of State's monthly administrative register and include the time and place of a hearing on the rule. The legality of all proposed rules, including emergency and public-necessity rules,

must be approved by the Attorney General and Reporter. Emergency and public-necessity rules are effective upon filing with the Secretary of State, and other rules are effective 75 days after filing.

Testwork revealed the following discrepancies:

- The Bureau is paying some providers more than is allowed by departmental rules. The method used to calculate outpatient hospitalization payments to providers caring for enrollees who are both TennCare and Medicare recipients sometimes results in payments that exceed limits. (See finding 16 for more details.)

- The Bureau has not revised its rules to include changes in the method it uses to determine payments to the state's medical schools for graduate medical education.

- The rules pertaining to the Home and Community Based Services waiver program have not been revised to reflect the changes in the program. For example, TennCare no longer pays provider claims based on a per diem rate.

Generally, rules are used to state a department's position on important matters, provide standard definitions of technical words and phrases, and define regulations and policies that affect parties outside state government. Departmental rules are to be developed in an open forum, using due process, so that the interests of all parties can be considered.

Recommendation

TennCare management and staff should comply with the Bureau's rules, and the Director of TennCare should take appropriate measures, including a system for monitoring relevant program changes, to ensure that the rules are revised to remain current.

Management's Comment

We concur. The Bureau will continue to review its departmental rules and operating procedures to ensure consistency. As determined appropriate, the rules or the procedures will be modified accordingly. Monitoring efforts will be established to ensure that departmental rules are consistent with operating procedures.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC) AND BLOCK GRANT FOR PREVENTION AND TREATMENT OF SUBSTANCE ABUSE (SAPT)

The other two major programs for the Department of Health were also audited for the applicable compliance requirements as noted in the U.S. Office of Management and Budget Circular A-133, *Compliance Supplement for Single Audits of State and Local Governments*. These two major programs are Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Block Grant for Prevention and Treatment of Substance Abuse (SAPT).

To address the objectives of the CAFR and the Single Audit, as they pertain to federal financial assistance programs, our audit focused primarily on the compliance requirements for WIC and SAPT.

The audit consisted of the following areas:

- Activities Allowed or Unallowable & Allowable Costs / Cost Principles
- Cash Management
- Eligibility
- Equipment and Real Property Management
- Matching, Level of Effort, Earmarking
- Period of Availability of Federal Funds
- Procurement and Suspension and Debarment
- Program Income
- Reporting
- Subrecipient Monitoring
- Special Tests and Provisions

Activities Allowed or Unallowable & Allowable Costs / Cost Principles

The primary objectives for both WIC and SAPT were to determine if

- funds were used for allowable purposes;

- federal expenditures were in compliance with grant requirements; and

- expenditures involving federal funds have been recorded correctly as to the applicable federal grant and the proper grant program.

An additional objective for WIC was to determine if:

- costs meet the criteria set forth in the "Basic Guidelines" of Circular A-87, *Cost Principles for State, Local and Indian Tribal Governments,* Attachment A, paragraph C.

Supporting documentation for all WIC and SAPT significant items was reviewed and tested to determine if funds were used for allowable purposes. The significant items were also tested for compliance with grant requirements and appropriate recording to the proper grant program. Also, where applicable, the items were tested for compliance with travel regulations, contract terms, and purchasing guidelines. Supporting documentation for all WIC significant items was reviewed and tested to determine if costs were in compliance with Circular A-87.

Our testwork indicated that the department's federal WIC and SAPT funds were used for allowable activities, expenditures were in compliance with grant requirements, and expenditures were recorded correctly as to the applicable federal grant and the proper grant program. WIC costs were in compliance with Circular A-87.

Cash Management

The primary objectives for WIC and SAPT were to determine if

- the department complied with the Cash Management Improvement Act Agreement between the State of Tennessee and the Secretary of the Treasury, United States Department of the Treasury; and

- the department's reporting of receipt and cost transactions to the Department of Finance and Administration was adequate.

For both WIC and SAPT, the department's policies and procedures for recording and reporting the costs and drawdowns to the Department of Finance and Administration were reviewed and discussed with the appropriate personnel. We selected a nonstatistical sample of drawdown transactions and compared the process dates of the expenditure transactions in STARS with the dates the funds were requested from the federal agency to determine if transactions were performed in compliance with the Cash Management Improvement Act.

Our testwork indicated that the department complied with the Cash Management Improvement Act Agreement between the State of Tennessee and the Secretary of the Treasury, United States Department of the Treasury. Also, the department's reporting of receipt and cost transactions to the Department of Finance and Administration was adequate.

Eligibility

The primary objective for WIC was to determine if the department makes the required eligibility determinations (including obtaining any required documentation/verifications), and that individual program participants were deemed to be eligible and only eligible individuals or groups of individuals participated in the program.

A nonstatistical sample of WIC participants was selected. We accessed the Patient Tracking and Billing Management Information System and reviewed each selected participant's records for the appropriate information to determine if the department made an appropriate determination as to whether the participant was income eligible, met the residency requirement, was given the correct status or category, and was certified for nutritional risk by a qualified nutritionist.

Our testwork indicated that the department performed the required eligibility determinations and only eligible individuals or groups of individuals participated in the program.

Equipment and Real Property Management

The primary objectives for WIC and SAPT were to determine if

- equipment items existed and were recorded on the property listing at the proper cost;
- equipment purchases charged to federal grants, if applicable, were in compliance with grant requirements; and
- disposition or encumbrance of any equipment acquired under federal awards was in accordance with federal requirements and that the awarding agency was compensated for its share of any equipment sold or converted to non-federal use.

A nonstatistical sample of WIC and SAPT equipment expenditures charged to the major federal programs was selected to determine if the equipment items existed and were recorded on the property listing at the proper cost. Supporting documentation was reviewed and the information was traced to POST and STARS to determine if equipment items purchased with federal funds were identified on the property system with the correct grant information and whether the purchase complied with the applicable federal regulations. Also, supporting documentation of surplus equipment was reviewed to determine if disposition of federally funded equipment was in accordance with federal requirements.

Based on our testwork, the equipment items existed, were recorded on the property listing at proper cost, and were purchased in compliance with grant requirements. However, not all federally funded equipment was recorded on the property listing with the proper federal funding source. Therefore, identification of federally funded surplus equipment and compliance with

federal requirements could not be determined. This deficiency, which is disclosed in finding 35, was department-wide and involved all federal programs.

Matching, Level of Effort, Earmarking

The primary objective for SAPT was to determine if the department met the required level of effort and earmarking. Matching is not a requirement of OMB Circular A-133 for the SAPT block grant.

OMB Circular A-133, *Compliance Supplement for Single Audits of State and Local Governments*, and other program guidelines were reviewed to become familiar with program objectives, procedures, and major compliance requirements. The amount of non-federal funds expended for the year ending June 30, 1999, and the average level of expenditures maintained for the preceding two-year period were obtained and reviewed to determine if the department maintained state expenditures for authorized activities in accordance with the level of effort requirements.

The state must maintain expenditures for Substance Abuse (SA) treatment services for pregnant women and women with dependent children in accordance with the level of effort requirements. Also the state must maintain expenditures of non-federal amounts for HIV and tuberculosis services in accordance with the level of effort requirements. The expenditures were traced to supporting documentation.

Required percentages of the block grant funds are to be expended for prevention and treatment activities regarding alcohol, for prevention and treatment of other drugs, for one or more projects to make available to individuals early intervention services for HIV disease at the sites where the individuals are undergoing SA treatment, and for the costs of administering the grant. The amounts of block grant funds were traced to STARS to determine if the required percentages were met.

Based on our testwork, the department met the required total amount of SAPT block grant funds and state funds expended. However, the amounts expended for HIV and women's services could not be traced to STARS, and, therefore, it could not be determined if the department had expended the required percentage of funds for HIV and women's services (see finding 33).

Period of Availability of Federal Funds

The primary objective for both WIC and SAPT was to determine if the department obligated federal funds within the period of availability and obligations were liquidated within the required time period.

Financial reports, contracts, and expenditures were reviewed and traced to supporting documentation to determine if funds were obligated and expended within periods allowed.

Based on our review of financial reports, contracts, and expenditures, the department obligated federal funds within the period of availability and obligations were liquidated within the required time period.

Procurement and Suspension and Debarment

The primary objective for WIC and SAPT was to determine if procurement of goods and services was made in compliance with the provisions of applicable regulations and guidelines, and that no subaward, contract, or agreement for purchase of goods or services was made with any debarred or suspended party.

For both WIC and SAPT, the department's purchases of equipment and supplies were handled through the Tennessee On-line Purchasing System (TOPS). We selected a nonstatistical sample of purchases from TOPS to test for compliance with requirements contained in the OMB Circular A-133, *Compliance Supplement for Single Audits of State and Local Governments*. In addition, all WIC and SAPT contracts were obtained and reviewed for the clause stating that the contractor had not been suspended or debarred and for the appropriate signature.

Based on our testwork, it appeared that management had complied with procurement requirements, including requirements concerning debarred and suspended parties.

Program Income

The primary objective for WIC was to determine if program income is correctly recorded and used in accordance with the program requirements.

The program income, which is the interest received on rebates, was traced to supporting documentation to determine if the program income components were properly identified and had been used for allowable purposes.

Based on our testwork, program income was correctly recorded and used in accordance with the program requirements.

Reporting

The primary objective for both WIC and SAPT was to determine if the required reports for federal awards included all activity of the reporting period, were supported by applicable accounting or performance records, and were presented in accordance with program requirements.

The required financial reports for WIC federal awards were reviewed for completeness and timeliness of submission. Line items on the *WIC Monthly Financial Management and Participation Report* and *WIC Program Annual Closeout Report* were traced to supporting documentation to determine if the reports were fairly presented and in accordance with program

requirements. The required monthly Commodity Supplemental Food Program (CSFP) and WIC dual participation reports were requested to determine if the department was producing and reviewing the reports timely.

For SAPT, the key line items on the *Summary of Tobacco Results by State Geographic Sampling Unit* were traced to adequate supporting documentation provided by the Department of Agriculture to determine if the department was performing the required inspections of establishments that sell tobacco products.

Based on our reviews and testwork, the required reports for federal awards included all activity of the reporting period, were supported by applicable accounting or performance records, and were presented in accordance with program requirements. However, the department did not produce the monthly CSFP and WIC reports to detect dual participation as disclosed in finding 32.

Subrecipient Monitoring

The primary objectives for both WIC and SAPT were

- to follow up prior audit findings;
- to determine if the department monitored subrecipient activities to provide reasonable assurance that the subrecipients administer federal awards in compliance with federal requirements;
- to determine whether program subrecipients were monitored for compliance with program guidelines; and
- to determine if the department's procedures for obtaining and reviewing subrecipients' audit reports to identify and resolve subrecipient weaknesses in internal control, instances of noncompliance with subrecipient agreements, and questioned costs were functioning in accordance with prescribed requirements.

The department's procedures for monitoring local agencies' eligibility and activity, for monitoring program subrecipients at both program and fiscal levels and for evaluating authorized vendors were reviewed and evaluated for adequacy. A nonstatistical sample of monitoring reports was reviewed to determine if the special requirements, as described in the program guidelines and regulations, were included in the monitoring report. The department's procedures were reviewed to determine if the department obtained and evaluated subrecipients' audit reports timely. We also tested a nonstatistical sample of audit reports to determine if monitoring results were documented and whether deficiencies were corrected appropriately and timely.

Based on our review and testwork, the department's program and fiscal monitoring of subrecipient activities to provide reasonable assurance that the subrecipient administers federal awards in compliance with federal requirements was adequate. Also, the department's monitoring of program subrecipients for compliance with program guidelines was adequate.

However, the department's procedures for obtaining and reviewing subrecipients' audit reports for the purpose of identifying and resolving subrecipient weaknesses in internal control, instances of noncompliance with subrecipient agreements, and questioned costs were not adequate. See the repeat finding 34.

Special Tests and Provisions

One to One Reconciliation

For WIC, the primary objective was to determine whether the department's food instruments reconciliation process complied with the one-to-one reconciliation requirement.

Reconciliation reports of redeemed food instruments and exception listings were reviewed to determine that the department's non-reconciliation rate did not exceed one percent. We reviewed the department's controls over the bank's contract with WIC to determine if food instruments were redeemed in compliance with the federal requirements.

Based on our reviews and testwork, the department's reconciliation process of food instruments complied with the one-to-one reconciliation requirement.

Management Evaluations

For WIC, the primary objectives were to determine whether the department has conducted the required local agency management reviews and that the local agency management reviews cover the required areas.

The Summary of Clinic Reviews and Clinic Listings were obtained and a nonstatistical sample was tested to determine if the department conducts the required local agency management reviews, including a minimum of 20% of on-site visits of the clinics in the region. Also, the sample was tested to determine if the local agency management reviews covered the required areas.

Our reviews and testwork indicated that the department has conducted the required local agency management reviews and the reviews covered the required areas.

Independent Peer Reviews

For SAPT, the primary objectives were to determine whether (1) the required number of entities were peer reviewed, (2) the selection of entities for peer review was representative of entities providing services, and (3) the state ensured that the peer reviewers were independent.

We obtained and reviewed the listing of agencies providing treatment programs and the listing of agencies receiving peer reviews to determine if the number of entities reviewed was in compliance with the federal requirements. Also, a nonstatistical sample was tested to determine if the selected entities for peer review were representative of entities providing service and that the department ensured that the peer reviewers were independent.

Based on our reviews and testwork, the required number of entities were peer reviewed, the selection of entities was representative of entities providing services, and the department ensured the peer reviewers were independent.

Findings, Recommendations, and Management's Comments

32. The Department of Health has no procedures to detect dual participation in the WIC and CSFP programs

Finding

The department has no procedures to ensure that dual participation between the Special Supplemental Food Program for Women, Infants, and Children (WIC) and the Commodity Supplemental Food Program (CSFP) will be detected. According to the state plan, the state will attempt to detect dual participation between local agencies by comparing information for WIC participants with that of CSFP participants. The query results are printed in the dual participation reports. However, no dual participation reports have been generated since February of 1998. Because the dual participation reports are not generated each month, participants may improperly receive benefits from both WIC and CSFP programs.

The *Code of Federal Regulations*, Title 7, Section 246.7(l)(1)(i), states that the state agency "shall be responsible for . . . the prevention and detection of dual participation within each local agency and between local agencies."

Recommendation

The Director of the Bureau of Information Resources and the Supplemental Nutrition Program Director should assign specific responsibility for implementing an effective process to detect dual participation, including the generation of dual participation reports. They should also monitor operations to ensure the process is implemented and take corrective action when problems occur.

Management's Comment

We concur. Staff within the Supplemental Nutrition Program (WIC) have worked with staff within the Bureau of Information Resources (BIR) to implement an effective process for detecting dual participation, generating reports, and follow up.

Davidson County and Shelby County successfully implemented a new CSFP module within their Patient Tracking, Billing, & Management Information System (PTBMIS) in October 1999 which will register both populations (WIC and CSFP) to the same Master Patient File. Dyer County will install the same module by March 2000. MAP South (located with Shelby

County) will install the same module by July 2000. Utilizing the Master Patient File, a dual participation can easily be determined in either program within a region.

In order to determine dual participation between regions, BIR confirms that by March 2000, the CSFP caseload will be routinely uploaded to the Central Office AS400. This will allow the matching of populations of both CSFP and WIC to detect dual participation occurring across regional boundaries.

Reports will be generated quarterly in the Central Office and distributed to the regional WIC Directors for investigation. Regional WIC Directors will submit reports to Central Office within 30 days detailing results of their investigation in order to prohibit dual participation in both programs.

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33. The department's accounting for SAPT grant expenditures is not adequate

Finding

The department's accounting for the Block Grants for Prevention and Treatment of Substance Abuse (SAPT) expenditures is not adequate. The department has not established specific cost centers in the State of Tennessee Accounting and Reporting System (STARS) for classification of expenditures for HIV services and treatment services for pregnant women and women with dependent children (women). Without these specific cost centers for HIV and for women, the required expenditure levels cannot be traced to STARS.

The *United States Code* (USC) and *Code of Federal Regulations* (CFR) require that certain expenditure levels or percentages be maintained, in relation to the SAPT grant. The USC states that the grant must be expended for HIV services, not to exceed 5% of the grant. The CFR states that the state must have a level of expenditures at least equal to the amount expended in 1994 for treatment services for pregnant women and women with dependent children. Since the expenditure amounts cannot be traced to STARS and adequate supporting documentation could not be observed, the department has not fully complied with the grant regulations.

Recommendation

The director of Alcohol and Drug Abuse Services should designate cost centers in STARS to allow tracking of expenditures for all the required level of effort categories.

Management's Comment

We concur. Between June 28, 1999 and July 2, 1999, a review was conducted by an independent contractor on behalf of the Federal Center for Substance Abuse Treatment's

Substance Abuse and Mental Health Services Administration. This review identified that the Department should establish specific cost centers in the State of Tennessee Accounting and Reporting System (STARS) for classification of expenditures for both HIV services and treatment services for pregnant women and women with dependent children. The Department has established a separate cost center for the classification of SAPT expenditures for the HIV program. However at this time, the expenditures for the treatment of pregnant women and women with dependent children cannot be identified as such. Therefore, establishment of a cost center would not currently be beneficial. As a result, technical assistance has been requested from the Center from Substance Abuse Treatment to assist the Department in determining compliance with the SAPT Block Grant expenditure requirements for services to pregnant women and women with dependent children. The Department will strive to establish an appropriate accounting methodology to ensure compliance with all SAPT Block Grant requirements.

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34. <u>Monitoring of subrecipients' audit reports is not adequate</u>

Finding

As noted in the seven prior audits, the Department of Health does not adequately monitor subrecipients' audit reports. Management concurred with the prior findings and made improvements. Follow-up testwork on the prior finding revealed that 23 previously outstanding subrecipients' audit reports were filed with the department during the audit period, while 4 audit reports were still outstanding as of June 30, 1999. Reports were received from three months to over three years late.

Although improvements had been made, testwork for the current audit period revealed that there were still problems. The department still does not ensure that subrecipients' audit reports are obtained within nine months of the subrecipient's fiscal year end, as required by Office of Management and Budget Circular A-133. Testwork on 54 subrecipients' audit reports initially due during the audit period revealed the following:

- Twenty-six subrecipients' audit reports were not filed within the nine-month deadline but were received by June 30, 1999. Sixteen of these reports were received within 30 days of the due date. The remaining ten reports were from one to seven months late.

- Ten audit reports had not been received as of June 30, 1999. These reports were three months late as of June 30, 1999.

In addition, the department did not meet federal requirements in the following instances:

- For 26 of 29 subrecipient audit findings (90%), the department could not provide evidence that a management decision had been issued. A management decision is the evaluation by the awarding agency of the audit findings and corrective action plan

and the issuance of a written decision as to what corrective action is necessary. Two of the management decisions observed did not state whether or not the finding was sustained, the reasons for the decision, any description of an appeal process, and the audit finding reference number. The one remaining management decision was not issued within six months of receiving the subrecipient's audit report.

- Eight of 60 subrecipients (13%) did not have the Schedule of Findings and Questioned Costs in their submitted audit reports. These required schedules were not subsequently requested by the department. According to OMB Circular A-133, the three required components include a summary of the auditor's results, findings relating to the financial statements, and findings and questioned costs for federal awards.

- No actions were taken against subrecipients not obtaining an audit in accordance with OMB Circular A-133.

OMB Circular A-133 states that it is the pass-through entity's (Department of Health's) responsibility to "issue a management decision on audit findings within six months of receipt of the subrecipient's audit report." The management decision shall include "the expected auditee action to repay disallowed costs." The circular requires that the management decision "shall clearly state whether or not the audit finding is sustained, the reasons for the decision, . . . any appeal process," and the audit finding reference numbers.

OMB Circular A-133 also states that "the auditor's report(s) shall . . . include . . . a schedule of findings and questioned costs." Furthermore, it states that "in cases of continued inability or unwillingness to have an audit conducted in accordance with this part, . . . pass-through entities shall take appropriate action using sanctions such as . . . withholding a percentage of Federal awards until the audit is completed satisfactorily" or "suspending Federal awards until the audit is conducted."

Furthermore, the department did not meet other state requirements in the following instances:

- The Office of Audit and Investigations does not request copies of audit reports from county governments who are audited by the Comptroller of the Treasury. The county governments are considered to be subrecipients, requiring audits under OMB Circular A-133.

- One of 60 subrecipients did not have a Schedule of Expenditures of Federal Awards in its submitted audit report and the schedule was not requested.

It is the responsibility of the audited entity to provide the Department of Health with the audits. The standard audit clause states that "copies of such audits shall be provided to the State Granting Department." The standard audit clause also states that "any such audit shall be performed in accordance with . . . the Audit Manual for Governmental Units and Recipients of Granting Department." The Audit Manual for Governmental Units and Recipients of Grant

Funds requires the Schedule of Expenditures of Federal Awards and State Financial Assistance to be included in the audit report. However, it is ultimately the department's responsibility to track its grants and ensure compliance with applicable requirements.

The department cannot comply with applicable laws and regulations if it does not adequately monitor subrecipients' audit reports.

Recommendation

The department should ensure that subrecipients' required audit reports are received no later than nine months following their fiscal year end, the management decision resolving questioned costs is issued within six months of the receipt of the audit report, and the required schedules are contained in the audit reports. The Commissioner should take appropriate action using such sanctions as withholding a percentage of funding from any subrecipient when the required audit is not conducted or the audit report is not submitted to the department timely.

Management's Comment

We concur. Previously, the Comptroller's Office along with several state agencies recognized the tracking and timely receipt of subrecipient audit reports as well as the monitoring of questioned and disallowed cost were a problem for all departments. It was determined a new system of tracking and a central collection point for audit reports was needed in order for this process to improve or work more appropriately. The Department can only request audits but can not ensure the reports are received by a certain time. The only recourse being the withholding of reimbursement due the subrecipient or termination of the contract which in either case could hinder health service delivery to the citizens of the state.

The Department will continue to work with the Comptroller's Office and Department of Finance and Administration to develop a new tracking system and a central collection point for audit reports. Until such occurs, the Department will more aggressively pursue the receipt of audit reports within the required time frames and attempt to ensure all required supporting documentation is provided. Further, the Department will put more emphasis on reviewing questioned and disallowed cost and follow-up with timely management decisions and corrective action plans as warranted and necessary.

35. The department did not record correct grant-funding information in the state's property records

Finding

The department does not always record correct grant information (grant number and percentage of federal funds) into POST, the state's property and equipment-tracking system, for some equipment items purchased with federal funds. Testwork revealed the correct information was not entered for 7 of 57 federally funded equipment purchases. The 7 equipment items were 100% federally funded, but POST incorrectly listed the items as state funded. Incorrect funding information resulted because requesting employees did not record accurate information on the purchase request, and the property officer did not record accurate information on the purchase order.

In addition, 1 of 57 federally funded equipment purchases tested was not included on the department's property listing. Typically such errors would be discovered during the monthly reconciliation of STARS to POST. However, the property officer does not retain supporting documentation to indicate that these reconciliations were performed.

The department must be able to distinguish between state and federal property. The U.S. Department of Health and Human Services' "Public Health Service (PHS) Grants Policy Statement" states that, in certain cases, grantees should report income earned from the sale of equipment purchased with grant funds on the Federal Financial Status Report: "PHS has the right to require transfer of the equipment including title, to the Federal Government or to an eligible third party" (pages 8-14). If the equipment is damaged beyond repair, lost, or stolen, the recipient may be accountable to PHS for "an amount equal to the Federal share of the original equipment times the fair market value." If equipment purchased with federal grant funds is not correctly identified in the property records, the department's ability to transfer equipment, dispose of equipment, or reimburse the federal government in accordance with federal laws and regulations is greatly diminished. In addition, if equipment is not included on the property listing, an accurate inventory count cannot be achieved, and the department's accountability may be undermined.

Recommendation

Employees who initiate equipment purchases that are to be funded with federal funds should include correct grant information on the face of the purchase documents. Supervisors should verify that all funding information is complete and correct prior to approving the purchase documents. Also, the property officer should ensure correct grant funding information is stated on purchase orders and entered in POST, and should retain documentation of the reconciliation process between STARS and POST to ensure the department's property listing is accurate and complete. The Director of the Division of General Services should ensure that staff consistently

follow the procedures developed to ensure that the appropriate grant information is entered into POST.

Management's Comment

We concur. The Department will reinforce the policy of recording accurate grant information on the face of the purchase documents. The new property officer has been instructed that the grant number and the percentage of federal funding must be reflected on all purchase orders being procured for federally funded cost centers. In addition, the STARS to POST monthly reconciliation and documentation will be retained on file in order to ensure the Department's property listing is accurate and complete.

To address the objectives of the CAFR and to follow up prior audit findings, our audit included the following areas:

- Contracts
- Revenue
- Contingent/Deferred Revenue
- Expenditures
- Patient Tracking and Billing Management Information Systems (PTBMIS)

CONTRACTS

Our primary objective in the area of contracts was to follow up the status of prior audit findings. Our specific objectives were to determine:

- whether the department continued to enter into contracts that establish improper employer-employee relationships; and
- whether the department allowed contract services to be rendered before proper approvals of the contracts were obtained.

We interviewed key department personnel and reviewed terms of contracts, authorizations and dates, contract payment support, and memorandums.

Based on our testwork, the department had not entered into contracts that established improper employer-employee relationships. However, the department allowed contract services to be rendered before proper approvals of the contracts were obtained, as disclosed in repeat finding 36.

Finding, Recommendation, and Management's Comment

36. The department did not approve contracts before the beginning of the contract period

Finding

As noted in the prior audit, the department did not approve contracts before the beginning of the contract period. Management concurred with the prior finding and made improvements. In response to the prior audit finding, the department created an internal deadline to improve the process. However, testwork revealed

- 31 of 60 contracts reviewed (52%) were not approved until 2 to 60 days after the beginning of the contract period; and

- 10 additional contracts, which had an effective date of July 1, 1999, had not been properly approved, as of September 17, 1999.

Chapter 0620-3-3-.04(d)(8) of the *Rules of the Department of Finance and Administration* states that "upon approval by the Commissioner of Finance and Administration [the contract] shall be an effective and binding contract." If contracts are not approved before the contract period begins and before services are rendered, the state could be obligated to pay for unauthorized services.

The department issues many of its contracts pursuant to departmental grant authorities (DGA). The DGA is sent to the Commissioner of Finance and Administration for approval. Once this approval is obtained, then the Commissioner of Health or her designee can sign the actual contracts. In order to be properly authorized, contracts pursuant to the DGA require the Commissioner's signature or that of her designee. All other contracts require the original signature of the Commissioner.

Recommendation

The department's bureau directors should adhere to the department's deadlines for submitting contracts for review and Commissioner approval to help ensure that contracts will be completely approved before the beginning of the contract period.

Management's Comment

We concur. The Office of Budget and Finance works with the various bureau staff each year to encourage early submission of contracts for review and approval. However, with approximately 500 annual contracts to process each year, delays do occur resulting in instances where contracts have been signed after the beginning date of the contract. Notices have been sent to each bureau director outlining the necessary deadlines for contract processing to ensure that contracts are in effect on or before the contract beginning date. A report which lists departmental contracts which have a termination date of June 30, 2000 has also been sent to the bureau staff to assist them in their timely processing of contracts which will begin July 1, 2000. We will continue to encourage procedures and stress timeliness with both the programs and vendors in order to strive toward execution of approved and signed contracts prior to their start date.

REVENUE

Our primary objective was to follow up the prior audit finding to determine whether

- departmental controls ensured that transactions were properly supported, that receipts agreed with amounts deposited, that deposit slips were completed properly, that departmental records were reconciled with STARS, and that funds were properly controlled and deposited intact;
- revenue functions were adequately segregated;
- the Department of Finance and Administration's (F&A) policy for timely deposit of funds received had been followed; and
- the department complied with applicable federal rules, regulations, and guidelines when federal funds were involved.

Key department personnel were interviewed to gain an understanding of the department's procedures for and controls over revenue. We also reviewed supporting documentation and tested a nonstatistical sample of revenue transactions for proper support and for the appropriate requirements relating to controls over receiving, receipting, controlling, safeguarding, and depositing funds. Also, the transactions were tested for compliance with F&A's policy for timely deposit and federal rules, regulations, and guidelines when federal funds were involved. The reconciliation of the "Listing of Certification of Deposits in STARS" was obtained and reviewed, and petty cash counts were performed for each division in the department.

Based on our interviews, review of supporting documentation, and testwork it appears that the department's internal controls were in place, the revenue transactions were in compliance with the applicable requirements, the funds were properly deposited intact, the revenue functions were adequately segregated, F&A's policy for timely deposits was followed,

and the department complied with applicable federal rules, regulations, and guidelines.

CONTINGENT AND DEFERRED REVENUE

Our objectives were to determine whether

- contingent/deferred revenue accounts were used for the intended purpose;
- transactions were properly supported;
- only applicable items were recorded as contingent or deferred revenue and in the proper amounts;
- revenue was transferred from contingent/deferred to earned when the applicable criteria were met;
- the department had complied with applicable federal rules, regulations, and guidelines when federal funds were involved; and
- large variances between current and prior-year ending balances could be reasonably explained.

We interviewed key department personnel to gain an understanding of the department's procedures for and controls over deposits into the subaccounts and transfers to earned revenue to determine if contingent/deferred revenue accounts were used for the intended purpose. We also reviewed supporting documentation and tested nonstatistical samples of deferred revenue transactions to determine if only applicable items were recorded as contingent or deferred revenue and for the proper amount, revenue is transferred out of the subaccount when it is earned, and the department complied with applicable federal rules and regulations. We also compared June 30, 1999, subaccount balances with balances reported at June 30, 1998, and obtained explanations for significant variances.

Based on our testwork, the contingent/deferred revenue accounts were used for the intended purpose, revenue transactions were properly supported, and contingent/deferred revenue was deposited properly into and transferred out of the subaccount when the applicable criteria were met. Testwork also revealed that the department complied with applicable federal rules and regulations. Also, based on comparison of the current and prior-year balances, the large variances were reasonably explained by department personnel.

EXPENDITURES

Our objectives for reviewing expenditure controls and procedures were to determine whether

- expenditures for goods or services have been identified and recorded correctly;
- recorded expenditures are for goods or services authorized and received;
- auditee records are reconciled with Department of Finance and Administration (F&A) reports; and
- funds encumbered were liquidated for the same purpose as the original encumbrance.

We interviewed key department personnel to gain an understanding of the department's procedures for and controls over recording and reconciling expenditure transactions. We reviewed supporting documentation and tested nonstatistical samples for compliance with applicable requirements for expenditure transactions to determine if expenditures were correctly identified, recorded, authorized, and received, and that encumbered funds were properly liquidated. Also, supporting documentation of reconciliations of departmental records with F&A reports was reviewed.

Based on our testwork, expenditures were properly identified and recorded, recorded expenditures were authorized and received, and encumbered funds were liquidated properly. Also, the department's records were reconciled with F&A reports.

PATIENT TRACKING AND BILLING MANAGEMENT INFORMATION SYSTEM (PTBMIS)

Our objectives for reviewing PTBMIS controls and procedures were to

- obtain an understanding and assess the risk of PTBMIS critical general and application controls;
- document the design of PTBMIS;
- determine that the department had canceled terminated employee's access to PTBMIS; and
- determine and document the department's efforts toward PTBMIS year 2000 compliance.

We interviewed appropriate personnel to gain an understanding of PTBMIS. We administered the Electronic Data Processing section of the general planning and internal control questionnaire and reviewed organizational charts for the Bureau of Information Resources to document the design of PTBMIS. The general control policies and procedures concerning security, system changes, and contingency planning were reviewed and assessed to gain an understanding and assess the risk of the general controls. We also reviewed the application control policies and procedures concerning audit trail, input, processing, and output to gain an understanding and assess the risk of the application control. We tested a nonstatistical sample of

employee terminations to determine if access had been removed at the time of termination. The PTBMIS year 2000 compliance procedures were discussed with the appropriate personnel to determine the status of the compliance.

Based on our interviews and testwork, the design of PTBMIS was documented and the general and application controls were adequate and in place, the department made adequate effort toward PTBMIS year 2000 compliance, and terminated employees' access to PTBMIS was canceled.

DEPARTMENT OF FINANCE AND ADMINISTRATION POLICY 20, "RECORDING OF FEDERAL GRANT EXPENDITURES AND REVENUES"

Department of Finance and Administration Policy 20 requires that state departments whose financial records are maintained on the State of Tennessee Accounting and Reporting System (STARS) fully utilize the STARS Grant Module to record the receipt and expenditure of all federal funds.

Our objectives were to determine whether

- appropriate grant information was entered into the STARS Grant Control Table upon notification of the grant award, and related revenue and expenditure transactions were coded with the proper grant codes;
- appropriate payroll costs were reallocated to federal programs within 30 days of each month-end using an authorized redistribution method;
- the department made drawdowns at least weekly using the applicable STARS reports;
- the department had negotiated an appropriate indirect cost recovery plan, and indirect costs were included in drawdowns; and
- the department used the appropriate STARS reports as bases for preparing the Schedule of Expenditures of Federal Awards and reports submitted to the federal government.

We interviewed key personnel to gain an understanding of the department's procedures and controls concerning Policy 20 and the department's indirect cost recovery plan. We reviewed supporting documentation and tested nonstatistical samples of grant awards, revenue and expenditure transactions, drawdowns, and reports submitted to the federal government to determine if indirect costs were included in the drawdowns and drawdowns were made timely. All grant award notification dates were reviewed and compared to the awards listed on STARS to determine if grant award was entered timely. A nonstatistical sample of revenue and expenditure transactions was tested to determine if the transactions were coded properly. We also reviewed payroll cost reallocations and the schedule of expenditures of federal awards. Each grant's total expenditure amount on the schedule was traced to STARS.

Based on our interviews, reviews, and testwork, the department was in compliance with F&A Policy 20. The department had fully utilized the STARS Grant Module to record the receipt and expenditure of all federal funds, appropriate payroll costs were reallocated appropriately and timely, the department made drawdowns timely, and the proper indirect costs were included in the drawdowns. The department also used the appropriate STARS reports as bases for preparing the Schedule of Expenditures of Federal Awards and reports submitted to the federal government.

OBSERVATIONS AND COMMENTS

TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

Tennessee Code Annotated, Section 4-21-901, requires each state governmental entity subject to the requirements of Title VI of the Civil Rights Act of 1964 to submit an annual Title VI compliance report and implementation plan to the Department of Audit by June 30, 1994, and each June 30 thereafter. For the year ending June 30, 1999, the Department of Health (including TennCare) filed its compliance report and implementation plan on June 30, 1998.

Title VI of the Civil Rights Act of 1964 is a federal law. The act requires all state agencies receiving federal money to develop and implement plans to ensure that no person shall, on the grounds of race, color, or origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal funds.

On October 15, 1998, the Commissioner of Finance and Administration notified all cabinet officers and agency heads that the Human Rights Commission is the coordinating state agency for the monitoring and enforcement of Title VI.

A summary of the dates state agencies filed their annual Title VI compliance reports and implementation plans is presented in the special report *Submission of Title VI Implementation Plans*, issued annually by the Comptroller of the Treasury.

REVIEW OF NURSING HOME TAXES

As noted in the Tennessee Comprehensive Annual Financial Report for the year ended June 30, 1999, the Health Care Financing Administration has performed a review of the nursing home provider taxes collected for the period beginning fiscal year 1992 to the present. The purpose of the review was to determine the correlation between the provider taxes and a state grant program for private pay patients of nursing homes (Grant Assistance Program). The resulting draft-report has not been received by the State of Tennessee for review and comments.

AUDITOR'S COMMENT REGARDING TENNCARE

In January 1994, Tennessee withdrew from the Medicaid Program and implemented an innovative managed care health care reform plan called TennCare. This new plan was implemented within existing revenues and extended health care, not only to Medicaid-eligible Tennesseans, but also to many uninsured or uninsurable persons using a system of managed care. In order to implement TennCare, the state was granted a waiver by the Health Care Financing Administration (HCFA) for a five-year demonstration project. At that time, state rules were promulgated to assist in administering the statewide program of managed health care. The initial demonstration project ended on December 31, 1998. HCFA then approved a waiver extension for three years beginning January 1, 1999, through December 31, 2001.

The Medicaid/TennCare program involves multiple managed care networks, multiple agencies of state government, and most of the state's healthcare providers. The program, therefore, is extremely complex in its operations. Stability of the $4.5 billion program is critical. Due to the sheer size of the program, as well as the numerous federal and state regulations, it is essential that top officials in state government have commitment from all state departments and agencies that play a role in the delivery of health care to the state's Medicaid/TennCare eligible population.

Federal regulations require the designation of a single state agency to administer the Medicaid/TennCare program. During the audit period, the Department of Health was the designated state agency. However, in October 1999, the Bureau of TennCare was transferred from the Department of Health to the Department of Finance and Administration. In November 1999 federal approval was received to designate the Department of Finance and Administration as the single state agency. The single state agency is required to administer or supervise the administration of the state plan for the program. Given this authority, the single state agency must not delegate its authority to exercise administrative discretion in the administration or supervision of the state plan, nor may it delegate authority to issue policies, rules, and regulations on program matters. In addition, the authority of the single state agency must not be impaired if any of its rules, regulations, or decisions are subject to review or approval from other offices of the state.

The Bureau of TennCare and state officials are currently in the process of reforming the TennCare program. Although the state has saved money with the managed care system, top officials should continue to seek ways to maintain savings, improve payments to providers, and continue to provide quality health care services to the program's enrollees. Management should continue to strengthen the program from the foundation by focusing on strong internal controls and acquisition of an automated system designed specifically for the managed care environment. As noted in this report, the current TennCare Management Information System does not allow flexibility to efficiently and effectively support the massive Medicaid/TennCare program.

The current audit contains many findings, including repeat findings from several years. Notwithstanding these problems, current top management of the TennCare program has expressed an understanding of and commitment to the concept of a single state agency requirement which has not been evidenced in the past. In addition, it appears that management

intends to take positive steps to address the fundamental problems with the program, with regard to the development of written policies and procedures, particularly in the area of eligibility, and to try to achieve better accountability for TennCare resources. Furthermore, it appears that steps are being considered to improve the computer system and to address related issues to better facilitate the input, use, and exchange of information. Without such steps, it would be difficult to achieve all the improvements suggested in the current and prior audits. It appears that top management is committed to making the necessary changes; however, it will take some time to see marked improvement. Success in some areas of the program will be dependent on the administration's commitment to the single state agency requirement. To make this commitment work, it will be necessary for the administration to require all of the commissioners of the various departments involved in the program to effectively coordinate, cooperate, and comply with the directives of the TennCare bureau. Such efforts, which have not been successful in the past, cannot be directed by the TennCare program without the clear support of the office of the Governor.

TENNCARE'S MANAGEMENT'S COMMENT

The TennCare Program, which had its start on January 1, 1994, has been an extraordinarily ambitious effort by the state of Tennessee to offer health care to its neediest citizens. Tennessee was the first state in the nation to implement such a massive program. The multitude and complexity of challenges faced in the past six years have been staggering.

TennCare was conceptualized, planned, developed, and implemented within a period of about eight months in 1993. During the fall of 1993, contracts were developed with 12 managed care organizations to provide managed health care to the TennCare enrollees. The state of Tennessee as a whole had little experience with managed care, so learning the principles of managed care was a challenge for both providers and enrollees. In one day (January 1, 1994), the percentage of the state's Medicaid population enrolled in any form of managed care went from 3% to 100%.

As TennCare got underway, in addition to the estimated 800,000 Medicaid enrollees, an additional 350,000 new eligibles (uninsured and uninsurable people) began to be added to the program. An entirely new and separate enrollment process, as well as a never-before attempted premium collection process, was set up for the new TennCare enrollees, with the effort being to make enrollment and premium payment processes as simple and non-bureaucratic as possible.

At the same time the planning and implementation of TennCare were occurring, the state continued to run a fee-for-service Medicaid program. TennCare and Medicaid overlapped for a year after the start of TennCare, as the TennCare Bureau continued to process claims from providers for services delivered prior to January 1, 1994 and also continued those programs that did not become part of managed health care for enrollees. Most of the above work was done by the 200 staff persons, who were responsible for operating only the Medicaid program prior to the TennCare implementation.

There were many successes to report in the early days of TennCare. In one year the state's percentage of uninsured citizens dropped from 8.9% to 5.7%. The growth rate of Medicaid spending decreased dramatically. However, these successes did not come about without costs. The enormous effort required to accomplish the transition to TennCare and to adjust to never-envisioned situations and problems meant that some administrative processes did not receive the attention they deserved, which the Comptroller's audits over the years have duly noted.

As the program evolved, additional challenges were added. The massive modifications already made for TennCare were themselves modified to add a behavioral health carve-out program in 1996, a "TennCare for Children" program for uninsured children in 1997, a carve-out of mental health pharmacy services and the establishment of a reverification process in county health departments in 1998, and plans for an emergency fee-for-service system in 1999 and 2000. Lawsuits and responses to lawsuits during this period consumed an enormous amount of staff attention and resources. There has been great pressure from the managed care organizations and providers to examine funding levels available to TennCare. All of these activities have been accompanied by extraordinary media attention and scrutiny from advocates.

TennCare acknowledges that the findings of the Comptroller's audits over the years, some of which are repeat findings, point out administrative issues requiring our in-depth and sustained attention. While there have been efforts to address previously sited findings, we have taken the following steps in the past few months to continue to address the audit findings:

- We have engaged consulting staff to perform actuarial studies of the adequacy of program funding, to redesign our enrollment and reverification process for uninsured and uninsurable individuals, and to assist us in recruiting new managed care organizations to the program.

- We are strengthening our procedures for entering into and monitoring interagency agreements with other state departments which make use of TennCare funds in their operations.

- As the result of the legislative process, we are hiring additional staff to work in the areas of appeals, audit, legal representation, policy, finance, information systems, and quality oversight.

- We are strengthening our overall efforts to document policies and procedures at all levels within the TennCare organization and to insure that these policies and procedures are followed.

- We have designed an emergency fee-for-service system which could be implemented quickly if a major MCO were to leave the program unexpectedly.

- We are taking new steps to protect enrollees' due process rights through a greatly expanded appeals process.

We believe that the processes outlined above, as well as the commitment that seems to exist from providers, managed care organizations, and others with interests in TennCare's success, will have a significant effect on future audits. We appreciate the efforts of the Comptroller's Office to identify areas in our administrative processes which need to be strengthened and assure them of the intent to resolve the issues addressed at the earliest possible time.

APPENDIX

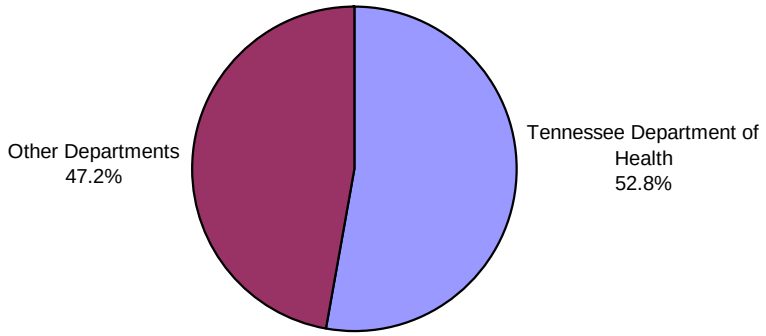
DIVISIONS AND ALLOTMENT CODES

Department of Health divisions and allotment codes:

343.01	Executive Administration
343.03	Office of Budget and Finance
343.04	Bureau of Information Systems
343.05	Bureau of Health Care Facilities
343.07	Emergency Medical Service
343.08	Laboratory Services
343.10	Health Related Boards
343.39	Environmental Sanitation
343.44	Bureau of Alcohol and Drug Abuse Services
343.45	Communicable Health Services
343.47	Maternal and Child Health
343.49	Communicable and Environmental Disease Services
343.52	Health Promotion and Protection
343.53	WIC Supplemental Foods
343.60	Aid to Local Health Units
343.65	TennCare Administration
343.66	TennCare Services
343.67	Waivers and Crossover Services
343.68	Long-Term Care Services
343.70	Nursing Home Grant Assistance Program

General Fund Expenditures

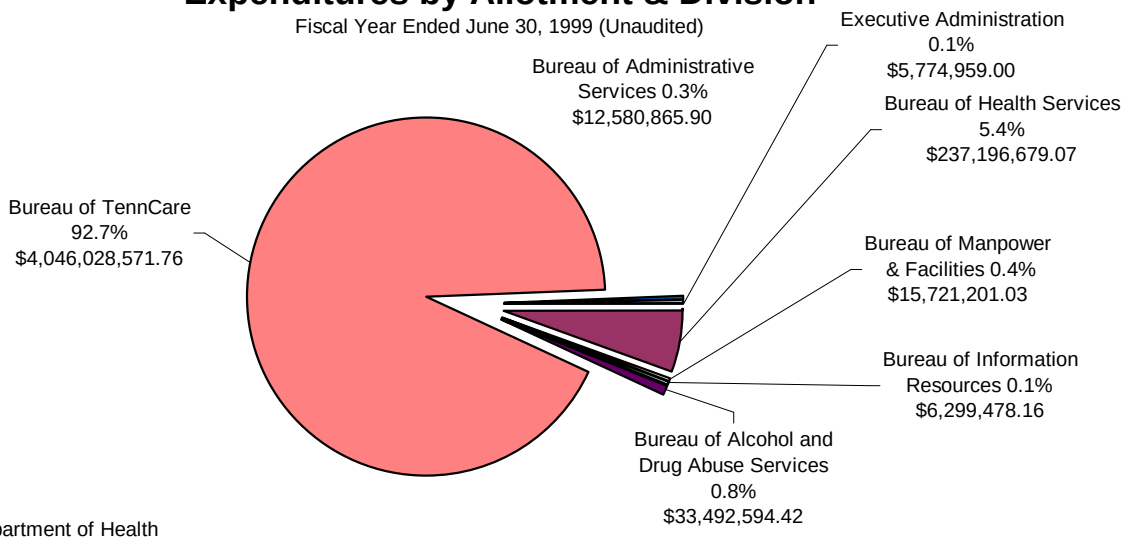
Fiscal Year Ended June 30, 1999 (Unaudited)



Source: Department of Health

Expenditures by Allotment & Division

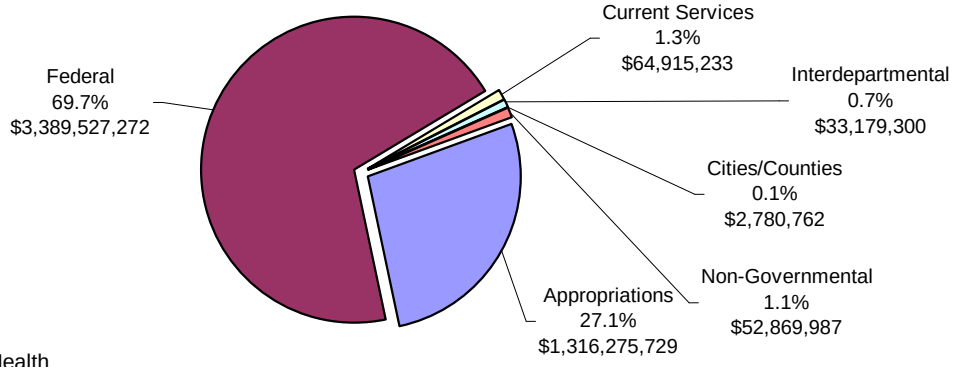
Fiscal Year Ended June 30, 1999 (Unaudited)



Source: Department of Health

Department of Health Funding Sources

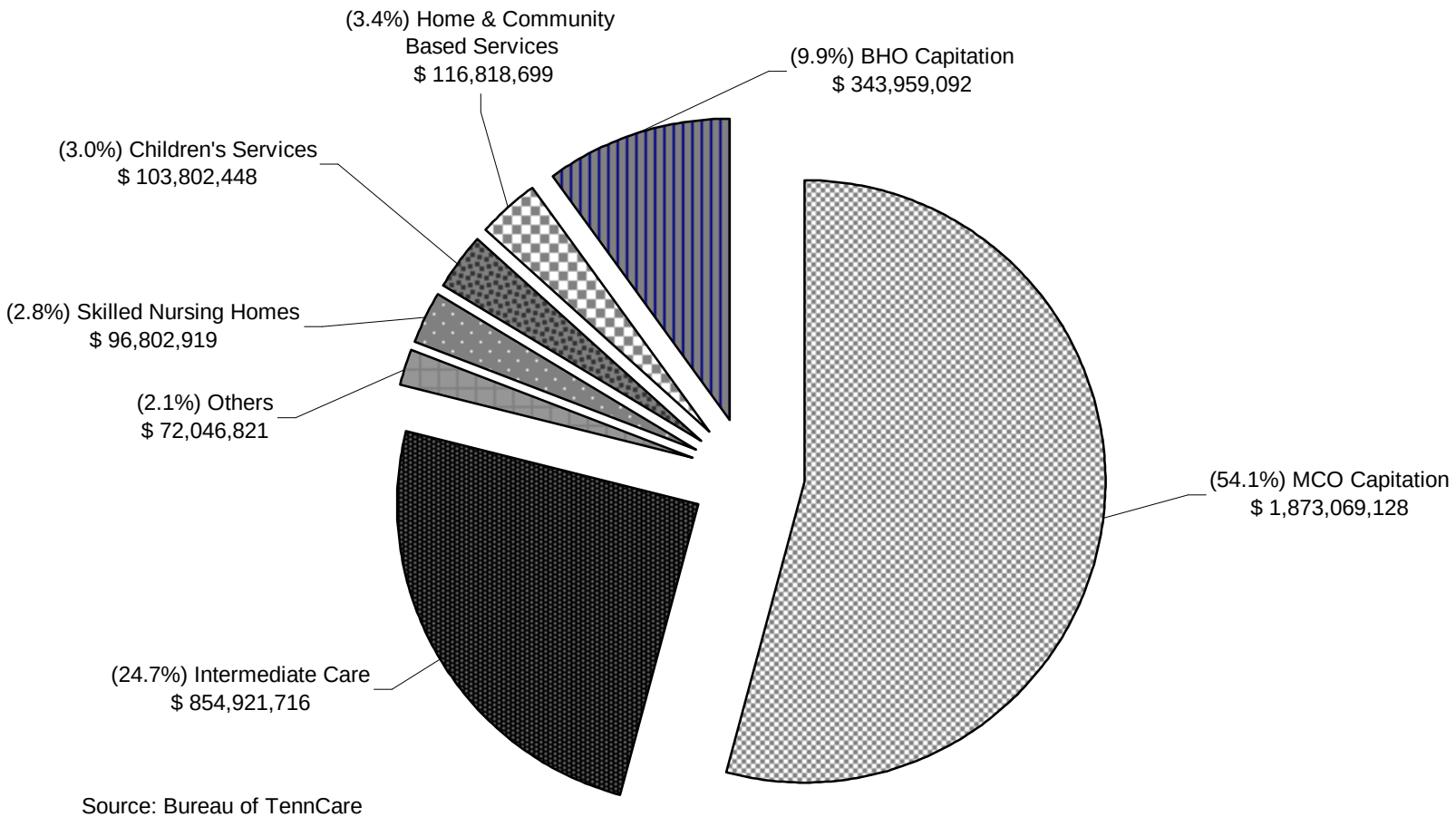
Fiscal Year Ended June 30, 1999 (Unaudited)



Source: Department of Health

TennCare Dollars Paid by Claim Type

Fiscal Year Ended June 30, 1999 (Unaudited)



Source: Bureau of TennCare